The impact of childhood sexual interaction on current psychological functioning in a male forensic population

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The Impact of Childhood Sexual Interaction on Current Psychological Functioning in a Male Forensic Population

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ABSTRACT

Little research attention has been paid to forensic populations of male survivors of childhood sexual abuse (CSA), where it is understood that prevalence rates are high. This study aimed to survey a sample of 40 men in a maximum security hospital who had experienced childhood sexual interaction (CSI). The study profiled the psychological functioning of the sample through a number of standardised measures and a semi-structured interview. In addition, the meanings that the men attached to their childhood sexual experiences, their 'constructions' of them, were also examined, along with their self-report of distress related to these experiences. The limited research conducted with male survivors suggests that men tend to construct CSI in more positive or neutral terms than female survivors, and are less likely to report distress related to the experience. However, men's experiences of CSI have still shown similar levels of association with psychological symptomatology in adulthood. This apparent discrepancy has been understood in terms of male socialisation.

The predictions that the men in this sample would show high levels of psychological symptomatology, which would be associated with the characteristics of CSI, and that the majority of them would describe positive or neutral constructions of CSI, and would tend to report no distress related to their experiences, were supported in this study. The implications of these findings are discussed. Overall, it is stressed that in order to fully understand the impact of CSA on males, and to provide appropriate approaches to interventions, a fuller appreciation of the role of male socialisation must be achieved.

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1.0 INTRODUCTION

There is now widespread awareness of the long-term psychological effects associated with childhood sexual abuse (CSA) experiences (Christo, 1997). However, the empirical support for this association has been derived largely from research with adult women (e.g. Ussher & Dewberry, 1995; Briere & Runtz, 1988; Bryer, Nelson, Miller & Krol, 1987; Herman, Russell & Trocki, 1986). This situation is unsatisfactory in the light of the growing recognition of the high prevalence of male survivors of CSA (Mendel, 1995).

1.1 Prevalence Research

Prevalence estimates of the sexual abuse of female children vary, and the situation for males is even less clear. This seems to result from the inconsistencies of prevalence studies that plague this area of research.

1.1.1 Definitions

Perhaps the primary reason for a lack of consistency in findings related to the prevalence of sexual abuse is the variability of definitions of CSA used. Boyd & Beail (1994) identify the dimensions along which definitions vary: the age differential between the abused person and the abuser, whether physical contact occurred, the age of the abused person, the power position of the abuser, whether force or threat was used and how the survivors themselves have defined their experiences. They refer to Fromuth & Burkhart's (1987) study which examined the effect that different definitions of CSA had on the reported prevalence in college men. They found that a comprehensive definition produced a prevalence rate of 22%, but this was halved when the definition included only adult perpetrators and excluded peer interactions.

Schechter & Roberge (1976) defined sexual abuse in childhood as dependent, developmentally immature children and adolescents being involved in sexual activities they do not fully comprehend, and to which they are unable to give informed consent. For the purposes of this study, this kind of less restrictive definition is considered to be the most adequate.

1.1.2 Other Methodological Difficulties

There are other methodological factors which contribute to the inconsistency of prevalence research in this area. These include the use of small samples and specific populations, failure to use control groups and the reliance upon retrospective approaches and self-report.

The latter is of particular salience when considering male survivors of CSA. It has been suggested that men under-report sexual abuse and that this suppresses true prevalence figures. The reasons for this are complex. McMullen (1990) has highlighted five elements which directly affect under-reporting by men: shock, embarrassment, fear, stigma, and self-blame. This issue will be addressed in more detail below.

Despite the lack of clarity regarding definitions and prevalence, it seems probable that the emerging picture is one of a far higher prevalence of CSA perpetrated against males than was once thought. Briere (1992) has concluded that by mid-teens, sexual contact with a 'substantially older' person has been experienced by a third of women and a sixth of men. Finkelhor's (1994) review of epidemiological studies found a range of prevalence rates from 3 to 29% for males. In an attempt to be more exact,

Violato & Genuis (1993) also examined the prevalence research and estimated a prevalence rate of the sexual abuse of male children of 11.5%.

1.2 The Lack of Research Attention on Male Survivors

Boyd & Beail (1994) suggest that there has been a lack of research attention on male survivors, and that this derives in part from a widespread denial of male abuse. However, although they recognise the importance of denial on an individual level, they believe that denial on a societal level has prejudiced research in this field: 'Researchers of sexual abuse appear to have been influenced by cultural denial of sexual abuse in males as evidenced by the many studies of sexual abuse which have failed to carry out gender analysis' (Boyd & Beail, 1994, p.37). Indeed, as highlighted by Johnson & Shrier (1987), it has been widely assumed that boys are not very affected by sexual abuse. Bolton, Morris & MacEachron (1989) suggest that this assumption is linked to the fact that people tend to be more protective of female than male children. Review articles of the long-term sequelae of CSA have also tended to focus on female survivors (e.g. Browne & Finkelhor, 1986), including even the most recent reviews, such as that of Christo (1997). Cahill, Llewelyn & Pearson (1991) agree that this focus reflects the bias in publications regarding the long-term effects of CSA.

It cannot be assumed that men who have experienced CSA will experience the same long-term difficulties as women. The limited research conducted with men suggests similarities, but also numerous differences. There are a number of studies which have included both male and female survivors, although women tend to form the large majority in these samples. Some analysis by gender has been conducted in these

studies, as secondary to the primary analyses. For instance, Roesler & McKenzie (1994) found that in their sample of 168 female and 20 male survivors, CSA contributed significantly to increased adult psychological symptomatology levels (including depression, self-esteem, trauma symptoms, sexual dysfunction and dissociation). Men in this sample were shown to have significantly higher levels of sexual dysfunction than the women.

1.3 Research Comparing Male with Female Survivors

A number of studies have set out to specifically compare male survivors with female survivors as their primary analyses. Briere, Evans, Runtz & Wall (1988) found that CSA was associated with previous suicide attempts and increased symptomatology as measured by a trauma symptom checklist, but no differences emerged between males and females in the sample. However, in a similar study, Sigmon, Greene, Rohan & Nichols (1996) found that female survivors reported significantly greater trauma-related distress than male survivors, including higher levels of anxiety, depression, and post-trauma symptoms. They hypothesised that the heightened psychological distress of female survivors resulted from more recent or ongoing sexual trauma, since the female survivors in this study were significantly more likely to also have experienced sexual victimisation after the age of 18.

Dalkin (1997) stresses that whilst many studies fail to highlight differences between male and female survivors, some have shown, usually through the use of more qualitative techniques, that there are sequelae which are far more common amongst men (e.g. Woods & Dean, 1984). These are: confusion or anxiety about sexuality,

inappropriate attempts to reassert masculinity through aggressive behaviour and recapitulation of the abuse experience.

1.4 CSA Sequelae

Despite the historical lack of research attention upon male survivors, there is now a growing body of research addressing the male experience. A number of empirical studies have focused on the later functioning of male survivors, and they have generated numerous proposed sequelae for men. A 'flavour' of the kinds of symptomatology encountered will be provided here, followed by a summary of the categories of possible sequelae.

1.4.1 The Sequelae Described in Research with Male Samples

In a non-clinical sample of 750 men, Bagley, Wood & Young (1994) found that those recalling multiple events of sexual abuse were distinguished from other respondents on the following indicators: higher rates of current or recent depression, anxiety, suicidal feelings and behaviour, and current sexual interest in or actual behaviour involving minors. Johnson & Shrier (1985) compared a sample of 40 male adolescent survivors with a sample of 40 male adolescents who did not report any experiences of sexual abuse. They found that 25% of the male survivors reported sexual dysfunction compared to 5% of the comparison group. Although not considered as symptomatology, Johnson & Shrier (1987) found a high rate of self-identification as homosexual in their sample of male survivors. This over-representation has been replicated in other studies (e.g. Mendel, 1995). Fromuth & Burkhart (1989) assessed symptomatology in two samples of college men. They found small, but statistically significant correlations between sexual abuse and negative psychological adjustment

(as assessed by a psychiatric checklist) in one of the samples. However, the generalisability of the results from these samples has been questioned. Mendel (1995) refers to Urquiza (1993), who found that male abuse survivors had fewer secure attachments and more avoidant attachments (as measured by an attachment interview) than men who had not experienced CSA. Kelly & Gonzalez (1990) used the Minnesota Multiphasic Personality Inventory (Dahlstrom & Welsh, 1960) in assessing the symptomatology of a group of male survivors. They found that the majority of the profiles generated by this group were indicative of personality dysfunction.

1.4.2 Psychiatric Sequelae

Many of the reported sequelae of CSA are represented in psychiatry's diagnostic frameworks, and this is not restricted to affective disorders. For instance, Stein, Golding, Siegal, Burnam & Sorenson (1988) conducted a large scale epidemiological study and found a higher frequency of psychiatric diagnoses in their sample of male survivors. This excess was entirely accounted for by substance misuse and antisocial personality disorder. Goff, Brotman, Kindlon, Waites & Amico (1991) although not conducting analysis by gender, examined the symptomatology of a sample of 61 patients with diagnoses of chronic psychotic disorder, sub-grouped by the presence or absence of a history of childhood abuse. They found that the 27 people who had reported childhood abuse had an earlier age of onset of psychotic symptoms, higher scores on a dissociation scale and relapsed more frequently. Within the 'abused' group, the 15 people who had reported sexual abuse had higher dissociation scores, were more likely to hear voices within their heads and to experience visual hallucinations, and had more relapses in the past year than those reporting only physical abuse.

Jacobson & Herald (1990) found that 26% of the 50 men in their psychiatric in-patient sample had experienced some sort of CSA. Similarly, Metcalfe, Oppenheimer, Dignon & Palmer (1990) found that 23% of their sample of 100 male psychiatric service users reported at least one experience of CSA. However, this figure doubled when a less restrictive definition of CSA was used; one which did not rely on minimum age differentials. Palmer, Bramble, Metcalfe, Oppenheimer & Smith (1994) used a control group in their study, and compared the incidence of CSA in the histories of men attending general practice surgeries with those attending psychiatric services. They found that the latter reported more frequent and more serious events before the age of 13 than the general practice attenders. They concluded that CSA before the age of 13 may be associated with later psychiatric disorders, although the nature of the association remains uncertain.

1.4.3 Summary of Sequelae for Men

Clearly, the range of possible sequelae is wide and it is difficult to offer a meaningful summary of the findings of the studies conducted. Mendel (1995) has summarised the findings across the body of literature by deriving six categories of long-term sequelae for men; emotional and psychological distress, relationship difficulties, sexuality and sexual problems, sexual orientation confusion, addictive behaviours and recapitulation of abuse.

1.4.4 Offending as a Sequel to CSA

Recapitulation of abuse and sexual offending have been identified as sequelae to CSA. Several investigators have interviewed convicted sex offenders and found high rates

of sexual abuse in their histories. Percentages of men reporting such victimisation range from 32% (Groth, 1979b) to 90% (Groth, 1979a). A significant proportion of patients in the English Special Hospitals[1] have committed offences which are sexual, including sexual abuse of minors (Taylor, 1997).

General offending behaviour has also been cited as a sequel to CSA. Taylor (1997) estimated that 40% of male Broadmoor Special Hospital patients have a childhood history of physical or sexual abuse. However, this estimate has to be treated with caution as a probable under-estimation because of the usual difficulties with prevalence research in this area. Heads, Taylor & Leese (1997) state that a considerable number of patients in Special Hospitals with a diagnosis of schizophrenia and a history of offending have experienced deprivation and abuse in childhood, including sexual abuse. Using a matched control group, Rivera & Widom (1990) found that childhood victimisation increased overall risk for violent offending, particularly for men.

1.5 Predictors of Adult Psychological Functioning

The literature on survivors of CSA also points to a number of specific characteristics of CSA which are associated with later psychological dysfunction, i.e. predictors of long-term effects have been proposed. Although research on this specific issue is still in its infancy, especially for male survivors, a number of factors have been found to be consistently associated. Mendel (1995) points out that a number of factors associated with abuse correlate with later psychological symptomatology in studies of female

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[1] The Special Hospitals treat offenders held under the Mental Health Act (1983). These patients are 'subject to detention' because they require 'treatment under conditions of special security on account of their dangerous, violent, or criminal propensities' (NHS Act, 1977).

survivors (e.g. Browne & Finkelhor, 1986; Herman, Russell & Trocki, 1986; Tsai, Feldman-Summers & Edgar, 1979). These include early onset of abuse, long duration of abuse, high severity of abuse, and closeness of relationship with the perpetrator. However, Mendel stresses that these factors have yet to be assessed adequately for male survivors. In addition, it seems that no studies of predictors have been conducted with samples of survivors who also have offence histories.

Mendel (1995) suggests that only the work of Kelly & Gonzalez (1990) represents a systematic assessment of the differential impact of varying aspects of abuse. They found early onset abuse and the presence of physical abuse with sexual maltreatment, to be the strongest predictors of negative outcome in their study. In his own research, Mendel (1995) found significant associations between numerous characteristics of the abuse experience and a number of indices of negative outcome. He concludes that close relationships with the perpetrator, longer duration and greater severity of abuse, and early age at onset of abuse, predict higher rates of later symptomatology in male survivors of CSA. However, it is important to stress that no single characteristic or predictor variable was associated with poorer outcome on all of the measures used; each outcome measure was associated with a different set of predictor variables. The findings suggest that these relationships can be very specific to the factors and individuals concerned, highlighting the complexity of the links between earlier experiences of sexual abuse and adult psychological functioning.

Whilst many studies report the existence of associations between the characteristics of abuse and adult symptomatology, there is a dearth of explanations of these specific

links. Llewelyn (1997) has suggested that it is not so much the age of the child which is significant, but the developmental stages across which abuse spans. Mendel (1995) has attempted to explain some of the other specific relationships. For instance, he suggests that abuse of longer duration acts to erode the self-esteem of the individual, and perpetration by a family member is likely to be experienced as a more profound betrayal and violation of the caretaking role.

Some authors have questioned the consistency of these specific relationships. Ussher & Dewberry (1995) refer to a 'major dispute' over the question of which factors associated with CSA are more likely to lead to later problems, and stress that these inconsistencies make it difficult to understand the mechanisms of the long-term effects of CSA. To date, research in this area has tended to take an exploratory approach, by investigating large numbers of different factors associated with CSA in order to determine the consistency of their relationships with adult symptomatology.

1.6 Explanatory Models of the Impact of CSA

A number of psychological models have been used to try and unravel the complexity of the impact of CSA, so that a clearer understanding of the possible causal relationships can be achieved. Llewelyn (1997) points out that various models have been proposed, but that partly as a result of the novelty of this research area, no consensus has been reached over the most appropriate model to be used in conceptualising the consequences of abuse. Llewelyn refers to three models: attachment theory (Alexander, 1992), developmental models (Cole & Putnam, 1992) and a transactional stress model (Spaccarelli, 1994). However, three further theories

will be outlined here, because when considered together, they can be seen to address the wide range of proposed CSA sequelae.

1.6.1 Post-Traumatic Stress Disorder (PTSD)

Although not a theoretical model as such, the clinical syndrome of PTSD (DSM-IV, 1994) has been proposed as an explanation for the development of CSA sequelae. PTSD is a group of symptoms displayed following a distressing event outside the range of usual human experience. DSM-IV lists the characteristic symptoms as: persistent re-experiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness, and persistent symptoms of increased arousal. Herman and colleagues (1986) have utilised this description to explain the specific long-term effects of CSA, and describe a formulation of PTSD which has become chronic and integrated into the survivor's personality structure: 'Memory of the original stressor may be partially or completely repressed, but fear and hypervigilance usually persist, and the trauma may be re-enacted in nightmares, intrusive "flashbacks", and dissociated states. Patients may attempt to protect themselves from these painful symptoms by withdrawing from sexual or intimate relationships in which the symptoms are likely to be evoked; such periods of withdrawal may alternate with re-exposure to repeated victimization' (Herman et al., 1986, p.1293). They go on to suggest that survivors may be driven to periodically seek relief from resultant depression, anhedonia and 'inner deadness' through substance and alcohol misuse, self-harm and suicide attempts.

There is certainly some empirical evidence available to confirm the presence of PTSD type symptoms in survivor populations (Lindberg & Distad, 1985). However, several

authors have questioned the utility of the PTSD model in explaining the full range of the long-term sequelae specific to the experience of CSA (e.g. Christo, 1997).

1.6.2 Traumagenic Dynamics

The traumagenic dynamics model described by Finkelhor & Browne (1985) and Finkelhor (1988) attempts to more directly address the sexualising effects of the trauma-generating factors of CSA. This model states that the dynamics of CSA shape the child's cognitive and emotional orientation to the world, and create trauma by altering their self concept, world view and affective capacities. Each of the four identified dynamics result from certain characteristics in the abuse situation and are related to particular long-term cognitive, affective and behavioural outcomes, as follows:

Traumatic sexualisation - As a result of being subjected to sexual activity, the child develops misconceptions about sexual behaviour and norms, and learns to associate sexual behaviour with these distorted beliefs, emotions and behaviours. This can create confusion about sexuality, sexual norms and the relationship between love and sex. Behavioural sequelae can include compulsive sexual behaviours and preoccupations, precocious sexuality, aggressive sexual behaviour and other sexual dysfunctions.

Stigmatisation - The child can develop a sense of being stigmatised by the negative messages associated with CSA; those that come from the abuser who blames and condemns them, and those from other adults who imply shame and blame. Dalkin (1997) suggests that the child's egocentric view of the world means that he or she

feels responsible for bad actions taken against them, and thus they may believe that they themselves are 'bad'. The impact of this includes guilt, shame, lowered self-esteem and a sense of being different from others. Behavioural sequelae include isolation, substance and alcohol misuse, criminal behaviour, self-harm and suicide attempts.

Betrayal - Abuse can violate the child's expectations that others will provide care and protection, resulting in depression, mistrust, anger, hostility or extreme dependency. There can also be grief at the loss of feeling safe and protected. These effects can lead to aggressive behaviour, delinquency, isolation and vulnerability to subsequent abuse.

Powerlessness - As well as feeling that trusted adults cannot always protect them, children often have to experience their inability to protect themselves when sexually abused. Their wishes and needs are disregarded, their body territory is invaded, there is often difficulty in making others believe disclosures and abusers may use force or manipulation. This powerlessness can provoke anxiety, fear and a lowered sense of efficacy. The child may develop an extreme need for control and identification with their aggressor in order to protect themselves, alternating with the overwhelming realisation of their own powerlessness. Behavioural sequelae include phobias, nightmares, depression, somatic complaints, dissociation, aggressive behaviour and vulnerability to subsequent victimisation or indeed, perpetration.

This is a comprehensive model. However, Christo (1997) says that it does not address factors that mediate the development of each dynamic and Mendel (1995) criticises it for not attending to the likely differences that exist for male and female children.

However, Kelly & Gonzalez (1990), having assessed the symptomatology of a group of male survivors, were able to place their symptoms in one of the four traumagenic categories. They conclude that male survivors do experience the dynamics of traumatic sexualisation, stigmatisation, betrayal and powerlessness, although they suggest that the psychological impact of such dynamics may be different for men as a result of the process of their socialisation. They call for further research on the gender-specific effects of sexual abuse.

1.6.3 Cognitive Theory

The dynamics described above can be seen to fit with schema-based cognitive theory, in as much as the shaping of the child's world view is seen as fundamental. In 1979 Beck defined schemas as 'stable cognitive patterns', that form a 'basis for screening out, differentiating, and coding the stimuli that confront the individual' (Beck, Rush, Shaw & Emery, 1979, pp. 12-13). Padesky (1994) says that people can develop unhelpful schemas about themselves, others and the world in response to negative life events, such as childhood abuse. Young & Klosko (1993) highlight how schemas are extremely rigid and concrete and can be very resistant to change. Jehu (1992) applied schema theory specifically to the personality problems experienced by survivors of CSA. He hypothesises that the experience of CSA is likely to establish maladaptive schemas which are maintained over long periods by cognitive distortions, self-defeating behaviour patterns and feelings of anxiety and hopelessness about changing schemata. Similarly, Janoff-Bulman (1989) focused on the schemas of survivors, or 'assumptive worlds' as she calls them. She says that trauma forces the person to reappraise their view of the world, either assimilating the trauma into their existing schemas or revising the schemas to accommodate the trauma.

Mendel (1995) finds Janoff-Bulman's model still wanting however, because it is derived from conceptualisations of trauma in general and therefore does not fully capture the specific impact of CSA. In particular, he emphasises that it is primarily a model, albeit a sophisticated one, of the cognitive impact of victimisation.

In summary, no single model has been proposed which fully conveys or explains the wide range of sequelae associated with the experience of CSA. It is perhaps fortunate that these models can be seen to be complementary as when they are considered together, they provide at least a framework for identifying and understanding the symptomatology of CSA survival. Perhaps it is useful to consider the models together: the dynamics of the CSA experience may shape schemas that are maintained in adult life, provoking resultant behaviours which can often act as defences against PTSD type symptoms resulting from the original sexualised trauma.

1.6.4 Models Linking Offending with Early Traumatic Experience

An increased understanding of the relationship between earlier experiences and offending behaviour is also emerging. As previously mentioned, Stein and colleagues (1988) found a high frequency of a diagnosis of anti-social personality disorder in a sample of male survivors. Porter (1996) has reviewed clinical and empirical evidence supporting the hypothesis that negative childhood experiences can profoundly affect emotional functioning in adulthood. He has proposed a pathway for psychopathic personality disorder in which environmental factors are critical. Specifically, he states that 'certain individuals who are severely traumatised or disillusioned by loved ones might over time learn to "turn off" their emotions as an effective coping mechanism,

later emerging as psychopathic personality disorder' (Porter, 1996, p.179). Luntz-Weiler & Widom (1996) found that survivors of childhood abuse had significantly higher scores on a psychopathy checklist than a matched control group. They suggest that childhood abuse may increase a person's risk for psychopathy which, in turn, may put them at increased risk for violent behaviour.

Burgess, Hartman & McCormack (1988) confirmed an association between sexual abuse and the 'externalising' behaviours of substance misuse, juvenile delinquency, and criminal behaviour. They concluded that survivors who go on to offend have developed ways of processing and managing their distress that increase their vulnerability to offending. Predominantly, offending behaviour (such as substance misuse and aggressive behaviour) can facilitate dissociation from the event by 'blocking' at a sensory, perceptual and cognitive level. The authors also stress that the survivor's denial of his position of vulnerability and helplessness as a victim enhances identification with aggression, thereby creating the link from abused to abuser.

1.7 Implications for Understanding the Impact of CSA on Men

In summary, the experience of CSA has been found to have a negative impact on adult psychological functioning, with the specific nature of the abuse covarying to some extent with the levels of symptomatology measured. This suggests that the characteristics of the experience may play a role in the mechanisms of developing sequelae. Theories have been proposed which describe the wide range of sequelae, and make some attempt to explain the mechanisms. However, as yet, no model of these mechanisms has been found adequate. Baker & Duncan (1985) stress that it is probably a complex interaction of many factors that determines which effects will be

experienced and subsequently reported. They say that the nature of the experience on it's own does not determine the outcome and that other factors must be considered.

For instance, theories of the development of psychological difficulties often stress the importance of the meanings attached to experiences; how the individual 'constructs' them (e.g. cognitive theory, Beck et al., 1979; attribution theory, Antaki & Brewin, 1982). The traumagenic dynamics model and schema-focused cognitive model both address constructions to some extent. However, social construction theory (McNamee & Gergen, 1992) stresses the influence of societal and cultural factors on the individual's constructions. The social constructions of masculinity and sexuality can be particularly powerful (Frosh, 1993) and perhaps this is why the theory related to the impact of CSA on men becomes further complicated.

Boyd & Beail (1994) suggest that gender differences in society reflect the qualitative differences in CSA as experienced by males and females. The gender stereotype of masculinity is synonymous with emotional and physical strength. This has implications for male help-seeking and reporting of sexual abuse. In addition, societal prejudices about male and female sexuality can exacerbate this situation.

1.7.1 Help-Seeking

The stereotype of masculinity is likely to have implications for help-seeking by men in general. O'Brien (1994) points out that men on average use physical and mental health-care services at a lower rate than women. Kessler, Brown & Broman (1981) investigated gender differences in psychiatric help-seeking and found that although women are assessed as having more emotional problems than men, there is also a

consistent tendency for women to seek psychiatric help at a higher rate than men with comparable emotional problems. The authors conclude that women translate non-specific feelings of distress into conscious recognition that they have an emotional problem more readily than men do. O'Brien (1994) reaches a similar conclusion: 'Symptomatic men may feel the same level of malaise or unhappiness as comparable women but may process these sensations through different sets of schemata in which the criterion for problem recognition is set at a different level' (p.18).

1.7.2 Under-Reporting of Male Sexual Abuse

Further, the powerlessness experienced during sexual victimisation for a male carries the message of reduced manhood and for many men, this prevents the personal acceptance and disclosure of an experience as abusive, let alone the seeking of help from others (Lisak, 1993; Dimock, 1988). Of course, this is likely to result in the under-reporting of male sexual abuse. Prevalence rates derived from community surveys are higher than estimates based on reports to professionals in clinical samples (Watkins & Bentovim, 1992). Mendel (1995) refers to a number of studies of male survivors that have found that the vast majority had never disclosed their abusive experiences and that boys were more reluctant to disclose than girls (e.g. Myers, 1989; Nasjleti, 1980).

The literature refers to other reasons for under-reporting which are related to the position of men. For instance, male survivors may have their pre-existing fears of homosexuality, or of being labeled homosexual, seemingly confirmed by the male perpetrated abuse experience (Watkins & Bentovim, 1992). Boyd & Beail (1994) suggest that the tendency for professionals to believe that male survivors are likely to

recapitulate their own victimisation probably reflects societal beliefs, and that this must further suppress reporting because of fear of 'guilt by association'.

1.7.3 Female Perpetration

The message of reduced manhood can perhaps be magnified when the victimiser is female. The picture is perhaps even more complex when the perpetrator is the person's mother. Indeed, there is growing realisation of the true extent of female perpetration (Krug, 1989; Elliott, 1994). Fritz, Stoll & Wagner as long ago as 1981, found that most male sexual abuse was heterosexual (60%).

Further, there is strong agreement with Bolton and colleagues (1989) who see male sexual socialisation, as it derives from the male stereotype, as defining all sexual experiences as desirable, providing there is no same sex content. This means that female perpetrated sexual abuse is less likely to be constructed by the individual or wider societal systems as abusive. For example, Elliott (1997) refers to the recent case of a 33 year old woman who started a sexual relationship with a 13 year old boy and received a sentence of two years probation. She contends that a male perpetrator would have received a more serious sentence and if a woman has sex with a male child it is assumed that she has not taken unfair advantage of his age or immaturity. In this case, because the boy was physically capable of having sexual intercourse, she believes that there was an expectation that the boy should bear some of the responsibility: 'And underlying this is often a sort of sniggering, public school assumption out of the social Dark Ages that older women have always initiated boys into sexual acts' (Elliott, 1997, p.47).

1.7.4 Men Construction's of the CSA Experience

Mendel (1995) hypothesises that, as a result of these cultural forces, the sexual abuse of males is only apparent because of problems secondary to the abuse itself. Fritz and colleagues (1981) concluded from their research that 'males and females differed in their qualitative assessment of the effect of early sexual experiences on current sexual attitudes and relationships...Females tended to assign a decidedly harmful, negative quality to their pre-pubescent sexual experience while males were neutral or even positive about it' (p.56). Following their research with male survivors in a psychiatric population, Metcalfe and colleagues (1990) reached a similar conclusion. Very few participants expressed the view that CSA had affected them adversely. The authors concluded that men may come to view childhood sexual experiences differently from women in accord with different views of sexuality in society. Gartner (1997a) stresses the difference between men and women in the way that they 'code' their sexually abusive experiences. He has suggested that women tend to 'know' that their experience was an abusive one, whilst men are much more likely to think of their abuse as 'sexual initiation', especially if the abuser is not a parent and is the same gender as the boy's eventual 'primary object' choice. For these reasons, the term childhood sexual interaction (CSI) is considered more appropriate for use in this study than CSA.

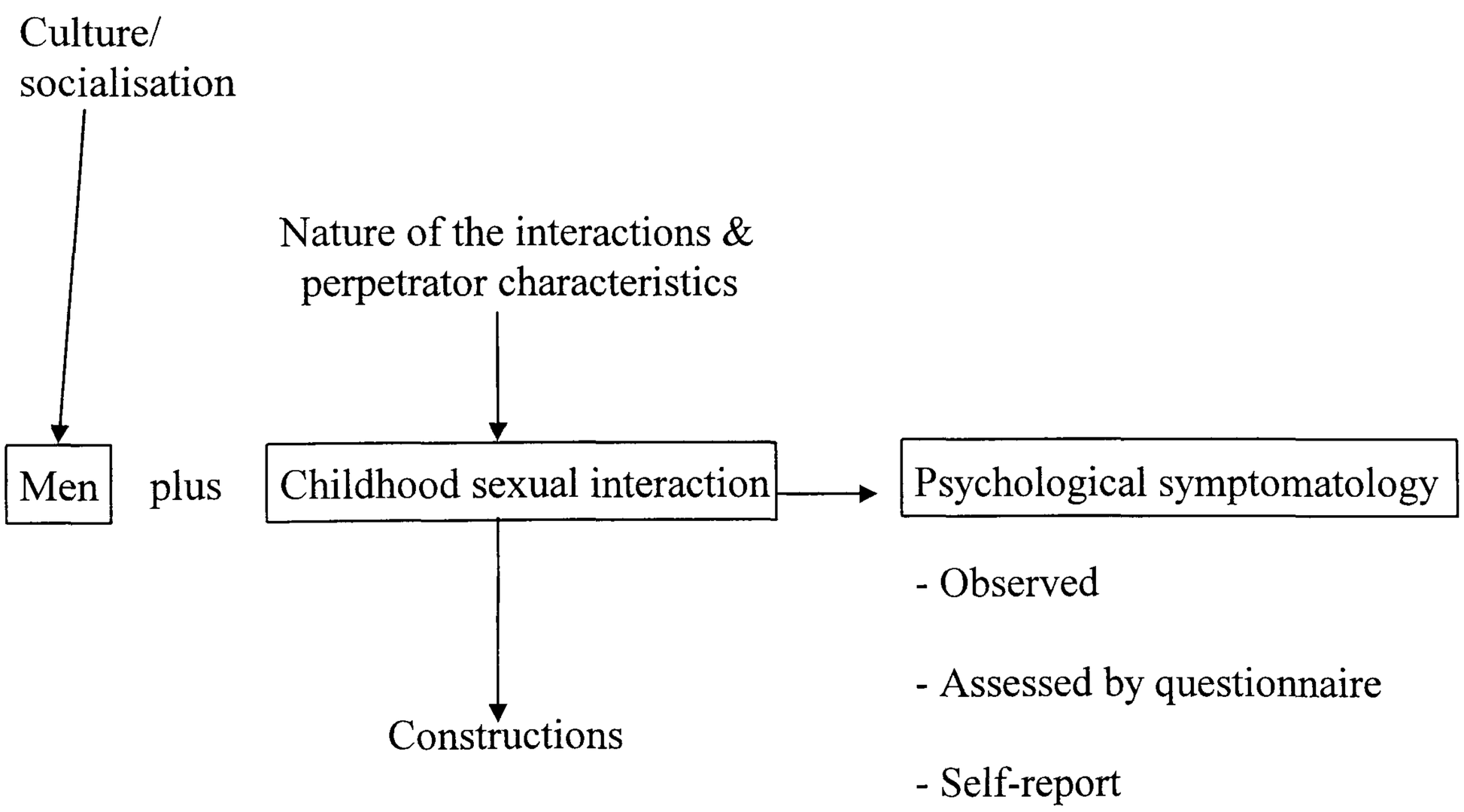
For some men, the subjective report of current distress related to CSI may be misleading. Boyd & Beail (1994) refer to Kaufman (1984) who stressed that men were much less likely than women to show an 'expressive' response and more likely to show a 'controlled' response to sexual assault.

Baker & Duncan (1985) found that men reported being significantly less damaged by their abusive experiences than females, but their psychological symptomatology showed the same levels of association with these experiences. Fromuth & Burkhart (1989) replicated this finding in their sample of men who reported predominantly female perpetrated sexual abuse. Sixty percent stated that they experienced these sexual interactions in childhood with interest and pleasure. However, the researchers found that this type of sexual interaction was still negatively associated with later psychological adjustment. They concluded that: 'Although to be consistent with a "male image" men may deny the abusive aspects of the experiences and report them as positive, these experiences still might have some implications for later functioning' (Fromuth & Burkhart, 1989, p.540). Unfortunately, Fromuth & Burkhart did not indicate whether there were any differences in outcome measures between those who experienced their sexual interactions benignly or positively and those who saw them as traumatic events (Mendel, 1995).

Mendel (1995) found that sexual activity between parents and children was associated with multiple negative outcomes regardless of whether or not it was considered abusive. He concluded that CSI, even if not considered abusive, may have pathological sequelae. Although he was not able to analyse his data to investigate the effect of framing CSI as abusive, he recommended such investigation as a valuable avenue for future research, which: '...could shed light on the role of the individual's construction and interpretation of his life experiences in determining the impact of these experiences' (Mendel, 1995, p.165). Indeed, Bolton and colleagues (1989) assert that looking only at sexual interaction that is constructed by the survivor as negative inevitably underserves males, who are less likely to view such interactions as abusive.

In summary, there is as yet no agreement regarding the most appropriate theory to explain the full impact of CSI on psychological functioning in adulthood. CSI has been found to have a negative impact on adult psychological functioning as indicated by symptomatology, and the levels of this symptomatology appear to be associated with the nature of the experience. The tendencies for men to construct CSI as positive and to under-report distress related to these experiences, despite the frequent presence of related symptomatology, are both seen to result from male socialisation. It seems likely, therefore, that constructions and self-report will be closely related. In overall summary, Figure 1 represents the factors relevant to this study which are considered to be important in determining the later impact of CSI on men.

Figure 1. Factors which may determine the later impact of CSI on men



1.8 Aims of the Present Study

The literature on male survivors is recent, and numerous unanswered questions remain. A number of these will form the focus for this study. They will not relate to the empirical investigation of one model of the impact of CSA, as this is not appropriate at this stage of knowledge. Instead, the associations between symptomatology and CSI found in the general male survivor literature will be empirically tested in the novel population of a male forensic sample of survivors. In addition, the role of constructions of the CSI experience will be explored.

First, although it is widely thought that forensic populations have high prevalence rates of CSI, little research has been conducted to explore its impact on this population. Consequently, the following research questions arise:-

1. What is the profile of psychological symptomatology (proposed long-term sequelae) in a forensic population of male survivors and how does this compare with the general literature on male survivors?

2. Which characteristics of CSI are the best predictors of psychological symptomatology in this population?

It is important to state that the hypothesis that psychological symptomatology will be associated with the experience of CSI *per se* cannot be tested in this study as all participants will be known to have such a history. The generation of a suitable control group of participants without this history would not be viable in this context. The control group would need to be comparable in terms of psychiatric diagnosis and

offending behaviour in order to make valid comparisons. However, it is believed that it is very likely that the majority of this psychiatric, offending population have experienced some sort of 'abuse' in childhood (Taylor, 1997), the extent of which is rarely revealed in initial assessments. Patients in this population may have chosen not to disclose this information and could consequently constitute a control group, thereby confounding the data. Therefore, the first hypothesis will address the possible associations between the characteristics of CSI and adult symptomatology. Specific predictions of these associations will not be made, as the literature remains exploratory in this area.

Hypothesis 1 - High levels of psychological symptomatology are expected in a Special Hospital sample, relative to the general population. The presence of psychological symptomatology is expected to be associated with the characteristics and nature of reported CSI (e.g. age at onset, relationship to perpetrator).

Secondly, there are different ways of constructing CSI (interpreting and reporting it as a positive or negative experience, for instance) and the nature of the impact of these constructions on outcome remains unexplored. In this study, the resultant further questions are addressed:-

3. How do men in this population tend to construct their experiences of CSI, and how do they tend to report their own reactions to these experiences?

4. Do these constructions have an impact on their psychological symptomatology?

5. Is there a difference between levels of psychological symptomatology as self-reported and as it is indexed by questionnaire-based assessment?

As research has suggested, it seems that men may often frame their CSI as non-abusive and report that they experience no distress related to it, but then have been found to show some psychological symptomatology as assessed by questionnaire measures related to the experience. Consequently, the further hypotheses are:-

Hypothesis 2 -It is predicted that the majority of participants in the sample will construct CSI in positive or neutral terms.

Hypothesis 3 -It is predicted that the majority of participants in the sample will report no distress in relation to their experiences of CSI.

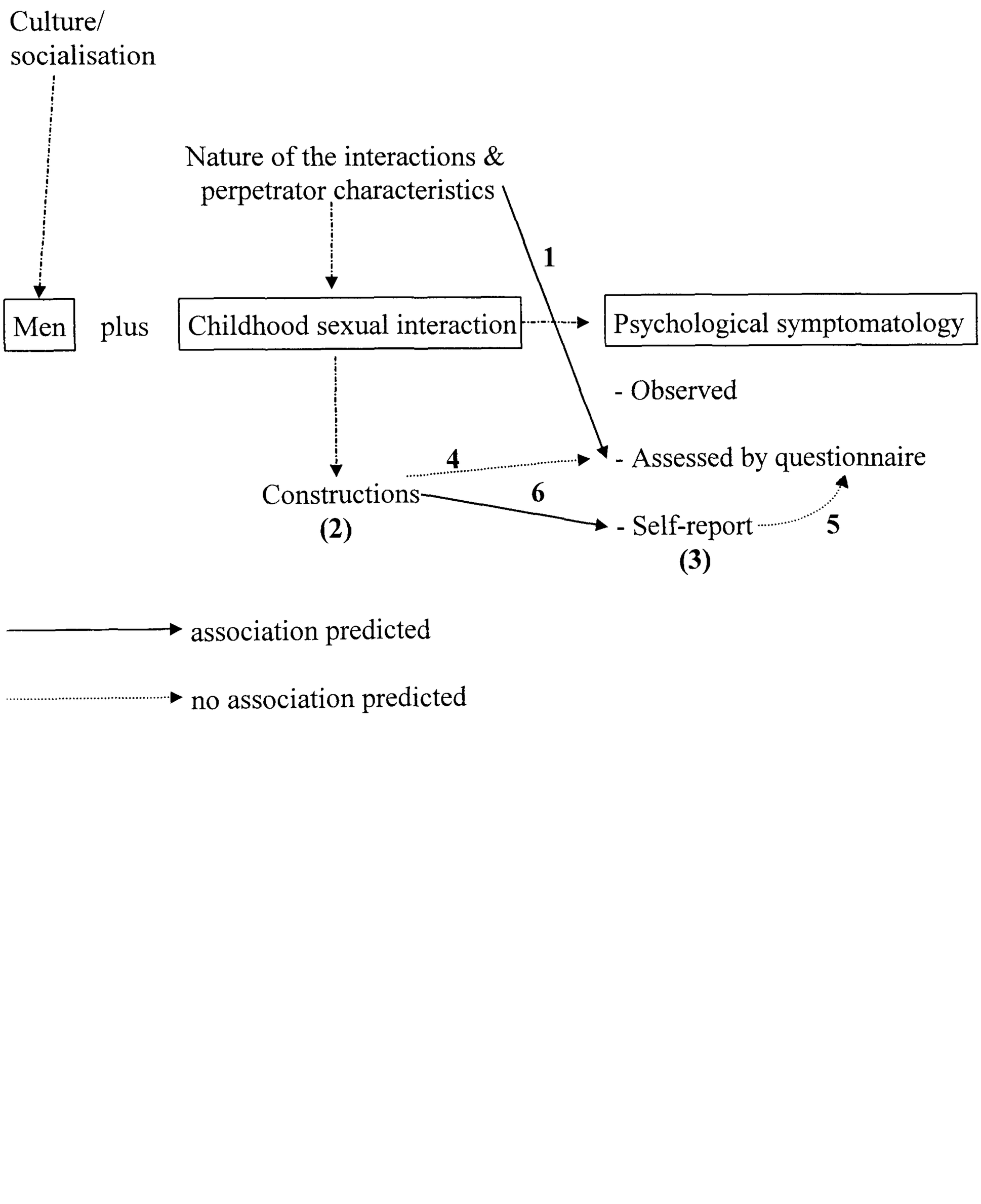
Hypothesis 4 - No significant difference is predicted in levels of psychological symptomatology as assessed by questionnaire measures between those who construct CSI negatively and those who construct it positively.

Hypothesis 5 - No significant difference will be observed in levels of psychological symptomatology as assessed by questionnaire measures between those who report distress as related to CSI and those who do not.

Hypothesis 6 - A significant relationship is predicted between subjective reporting of distress (as related to CSI) and the construction of these interactions: those who construct CSI as more positive will report less distress as related to their experiences.

In summary, Figure 2 represents the predicted relationships described in the hypotheses between the factors shown in Figure 1. The numbers indicate the hypotheses being represented.

Figure 2. Predicted relationships between the factors shown in Figure 1



2.0 METHOD

2.1 Design

This study surveyed a group of men with a known history of CSI in a maximum security hospital. Information was sought (via interview and case record analysis) about the participants' experiences of sexual interaction during childhood/adolescence.

Measures of each individual's current psychological symptomatology as assessed by questionnaire measures were treated as dependent variables (i.e. outcome), and the participants' constructions of the interactions, self-report of distress, and the particular characteristics of their experiences, as independent variables. For the purpose of analysis, the sample was also divided on the basis of the participants' constructions ('negative' or 'positive') of CSI experience, and by their level of self-reported distress. This allowed for between-group comparisons of current symptomatology as assessed by questionnaire measures.

2.2 Participants

Forty male participants took part in the study. All were resident in Broadmoor Special Hospital at the time of interviewing. The hospital has a total male population of approximately 380.

The population of the Special Hospitals comprise patients with either a diagnosis of personality disorder (under the legal category of 'psychopathic personality disorder'),

'mental illness' (for the majority, a psychotic disorder), or both. The sample selected in the present study is representative of this population, but those individuals considered to be floridly psychotic were excluded, as their current psychological functioning, and constructions of experiences in particular, may have invalidated their responses.

All participants had disclosed at least one sexual interaction under the age of 16 (with a person at least the same age or older) to one of the hospital's clinical psychologists. Their disclosure was considered by the psychologist to be significant in terms of the individual's psychosexual development.

For the purposes of the present study 'sexual interaction' comprises a broad range of activities described as 'sexual' by the participants, including 'playing doctor', looking at sexual pictures together, and sexual intercourse. This definition is based upon that used by Mendel (1995). The reasons for this choice of definition and inclusion criteria were as follows:-

1. One of the primary aims of the study is to explore the 'meanings' of the men's sexual experiences in childhood, and the relationship between these constructions and current functioning. Therefore, definitions which carry implications of the meanings of these experiences for the participants were avoided.

2. The body of literature has tended to depend upon very specific definitions of CSA and, as has been illustrated, this can restrict the range of experiences researched. It seems likely that inclusion criteria is usually determined by the researchers'

assumptions and personal values, and so events that have significance for an individual can often be missed. Boyd & Beail (1994) discuss this point: 'Problems with the quest for objectivity are illustrated by the difficulties in defining the nature of a sexually abusive act; this can only be defined in terms of an individual, his or her sexual socialization and familial context' (Boyd & Beail, 1994, pp.37-38).

An interaction can be experienced as abusive, or at least negative or distressing, for reasons beyond age differentials or the use of force (Dimock, 1985). 'Power' can have many sources, including developmental differentials which can be sexual, physical or intellectual (Peake, 1989), those based on gender, social class, ethnicity and sexual orientation, and perhaps more subtle distinctions such as personality factors.

3. Whilst the problems associated with 'self-definition' of abuse are acknowledged (e.g. idiosyncratic definitions reduce comparability and therefore generalisability of findings), it is argued above that labeling by others of CSI as abusive can conflict with the survivors' experiences, and may influence men's willingness to disclose.

4. The use of the word 'abuse' is also avoided for ethical and therapeutic reasons. The direct discussion of, and focus upon, these experiences could potentially be disruptive or re-traumatising for participants. Many survivors exhibit characteristics that appear to enhance their vulnerability to therapist abuse (Jehu, 1994). Consequently, every attempt was made to minimise the possibility of re-abusing the participant. The interview approach was designed to limit the likelihood of such difficulties: the disclosure of life experiences was under the

participants' control, and sexual abuse was not indicated as the only focus of the interview.

2.3 Procedure

2.3.1 Ethical Approval

Full ethical approval for this research was received from the Special Hospital's research and ethics committee. A copy of the letter stating this consent is presented in Appendix 1.

2.3.2 Recruitment

Potential participants were identified by clinical psychologists working with the patients. The responsible medical officer (RMO) and clinical team of each identified patient were informed of the study (Appendix 2) and were formally asked for their consent to approach the patient. With consent, each patient was approached by the researcher, and the study explained to them verbally and by a written outline which was left with them (Appendix 3) so that they could consider their participation. On average, they were approached again by the researcher after one week. Those who agreed to participate were asked to sign a standard hospital consent form (Appendix 4).

2.3.3 Interview Procedure & Data Collection

Background and demographic information was sought from the participants' files. This was used to corroborate or augment the information provided by participants

about the nature of their reported CSI. It was hoped that the minimum amount of information about each interaction would comprise: age at onset, duration, gender of perpetrator and relationship to perpetrator. The information held on participants' files is believed to be reliable.

Participants were informed that the purpose of the interview was to discuss earlier life events. A brief, semi-structured interview (20-30 minutes) preceded the completion of a series of standardised questionnaires. At the start of the interview, each participant's ability to read English was informally assessed in order to decide whether they could complete the questionnaires or whether they would need the researcher's assistance.

The interview included the presentation of a questionnaire designed by the researcher (Appendix 5). This comprised a series of life events, including sexual interactions with differing 'types' of perpetrators/partners (differentiating between age, gender and relationship). The CSI items were presented in the context of other life events in order to encourage disclosure, as the questions could be read and responded to by the participant without having to directly discuss the experiences with the researcher. They were asked to indicate by circling 'yes' or 'no' whether they had experienced any of the events listed.

If participants had experienced a listed life event they were then asked to complete each of four likert rating scales, which represented their constructions of the experience then and now (from 'very bad' to 'very good' on a 5 point scale), and their report of distress relating to that event then and now (from 'very distressed' to 'not at all distressed' on a 4 point scale). If participants referred to a number of different

incidents (or series of incidents) and perpetrators/partners, they were asked, where possible, to consider and rate these separately.

The construction scale did not use abuse terminology as this could not be used without first providing definitions of abuse, and this was avoided in this study. However, the fact that a bad/good continuum may not perfectly correspond to an abusive/non-abusive continuum is recognised. Also, the distress scale could be considered a limited way of accessing the self-report of participants' reactions to their experiences. However, this is a difficult task to complete in research terms, and past research has tended to keep such measures simple (e.g. Baker & Duncan, 1985) for the sake of brevity and to aid data analysis. It also recognised that the use of these scales, with their arbitrary allocation of numbers to verbal meanings, although aiding data analysis, does limit interpretations of results.

If the participant reported feeling comfortable discussing CSI, a small amount of further qualitative information on participants' constructions of these interactions was sought. Such information included further elucidation of how they felt about these experiences. At the end of the interview the participants were given the opportunity to meet again with the researcher for debriefing, should they want it.

Following the semi-structured interview, participants were asked to complete a number of standardised measures in the presence of the researcher.

2.4 Standardised Measures

Standardised and validated measures of various aspects of psychological symptomatology were used. This included the assessment of sexual orientation, defined separately in terms of desires and behaviour, although homosexuality is not considered to be a 'symptom'. In order to facilitate the comparison of this sample with a non-psychiatric, non-offending sample of male survivors, the present study attempted to replicate the methodology of a published and methodologically sound research project conducted with an appropriate sample (Mendel, 1995). This study used the same measures as Mendel, with some further additions. The less familiar measures used are presented in Appendix 6.

The Trauma Symptom Checklist - 40 (Elliot & Briere, 1992) - This is a 40-item self-report symptom checklist which evaluates the particular symptoms that the researchers have found best distinguish adult survivors of childhood abuse from other clinical and non-clinical populations. The scale comprises six sub-scales: dissociation, anxiety, depression, sleep disturbance, sexual problems, and sexual abuse trauma index (SATI), and a total score. The SATI includes the seven items that Briere and his colleagues have found to discriminate most reliably between abuse survivors and those who have not experienced childhood abuse.

The TSC-40 has been shown to be a relatively reliable measure in terms of internal consistency, with subscale coefficient alphas typically ranging from 0.66 to 0.77, and averaging at 0.89-0.91 for the full scale. The Cronbach's alpha for the full scale has been shown to be 0.97 (Briere, 1996).

The TSC-40 and its predecessor have been shown to have predictive validity by consistently discriminating victims of a range of traumatic experiences from non-victims (e.g. Demare & Briere, 1995; Bagley, 1991; Magana, 1990).

The World Assumptions Scale (Janoff-Bulman, 1989) - This is a 32-item scale developed to tap respondent's basic assumptions about themselves and the world. Janoff-Bulman has used the schema construct to understand the role of these assumptions following traumatic events. The World Assumptions Scale (WAS) comprises three categories of assumptions: perceived benevolence of the world, meaningfulness of the world and worthiness of the self. These are further divided into specific assumptions, resulting in eight subscales: benevolence of the impersonal world, benevolence of people, justice, controllability, randomness, self-worth, self-controllability, and luck. These constructs are considered to be orthogonal and hence a total score is not derived.

The WAS has not yet been used widely in research and consequently, available psychometric data is limited. All of the eight subscales have been shown to have reasonable internal consistency, with alpha coefficients ranging from 0.67 to 0.78. Through discriminant analysis, two of the subscales: benevolence of the impersonal world and self worth, were found by Janoff-Bulman (1989) to discriminate most reliably between abuse survivors and those who have not experienced childhood abuse (Wilks lambda = 0.970, $p<.02$, and 0.981, $p<.015$ respectively). Consequently, Mendel (1995) has only analysed and published the data for these two subscales, although he included questions for all subscales in his battery of measures.

The Brief Sexual Function Questionnaire For Men (Reynolds, Frank, Thase, Houck, Jennings, Howell, Lilienfeld & Kupfer, 1988) - This is a 21-item questionnaire which assesses male sexual functioning. Much of the Brief Sexual Function Questionnaire for Men (BSFQ) concerns physiological sexual response, but this was not assessed in this study. As in Mendel's study, questions were included which relate to sexual orientation, frequency of sexual activity and sexual satisfaction. A question relating to retrospective sexual satisfaction (prior to incarceration) was added for the present sample, as it cannot be assumed that current sexual behaviour and levels of satisfaction in the context of incarceration are representative of the participants' 'normal' levels of functioning.

Due to the extensive adaptations undertaken with this questionnaire it is less relevant to refer to the psychometric properties of the unadulterated measure. Suffice to say that acceptable test-retest reliability, construct validity and concurrent validity have been demonstrated (Reynolds et al., 1988).

The Beck Depression Inventory - II (Beck, Steer & Brown, 1996) - It was felt that a measure of mood that was more comprehensive than those of the subscales of the TSC-40 should be used. The Beck Depression Inventory (Beck & Steer, 1987) is a measure which has been widely used across clinical and nonclinical populations. High reliability, construct validity and concurrent validity have been demonstrated. The Beck Depression Inventory - II (BDI-II) represents a refinement of the original measure and has been shown to have improved internal consistency, with alpha coefficients of 0.92-0.93. Test-retest reliability and the validity of the scale remain high.

The Culture-Free Self-Esteem Inventory - 2 (Battle, 1992) - The Culture-Free Self-Esteem Inventory (CFSEI-2) was used in its adult form and consists of 40 items, generating a total self-esteem score, and three subscale scores for general self-esteem, social/peer-related self-esteem and personal self-esteem. The lie scale, which represents 'defensive' responding, was not used in the analysis.

The alpha coefficients for the three subscales range from 0.57 for the social scale to 0.78 for the general scale and 0.72 for the personal scale (Battle, 1992). This suggests adequate internal consistency for the general and personal scales, but more questionable reliability for the social scale. Good test-retest reliability has been suggested by correlations ranging from 0.79 to 0.81. Good content and concurrent validity has also been described. For instance, correlations ranging from 0.71 to 0.80 were achieved when comparing the CFSEI-2 with another well-established measure of self-esteem (Battle, 1992).

3.0 RESULTS

Data analysis was completed using the Statistical Package for Social Scientists (SPSS) for Windows. The rationale for the choice of statistical analysis was guided by professional statistical advice and the criteria for parametric and non-parametric tests.

3.1 Response Rate

Table 1 provides details of the response to the recruitment procedure. Two thirds of the patients suggested as suitable for participation completed the interview procedure. The reasons for the eight patients refusing the initial approach by the researcher were often not furnished by staff members. When they were, they tended to be general, such as the patient stating a lack of interest in research. All six patients who declined to participate after discussion with the researcher said that they preferred not to talk about the past, apart from one who felt that he was spending enough time with a psychologist already. Three of the interviews were terminated early because the participants were finding it difficult to focus upon the interview. Two of these patients attributed this to their mental state at the time.

Table 1. Details of recruitment procedure

	Number of individuals
Patient names forwarded by psychologists	60
Completed	40
RMO consent withheld	3
Approached and refused	8
Individual refused approach	6
Interview terminated	3

3.2 Demographic Information

The demographic characteristics of the sample are shown in Table 2. The sample comprised mostly white, unqualified men with employment histories of unskilled work or predominant unemployment. The mean age of the sample was 35 years and 4 months (SD = 7 years 11 months).

Table 2. Demographic characteristics of the sample

	n=40	
Age		
Mean (years)	35 years 4 months	
SD	7 years 11 months	
Range	22 years 9 months - 55 years 10 months	
	n	%
Ethnicity		
Caucasian	33	82.5
Afro-Caribbean	6	15
Mixed	1	2.5
Educational level		
GCSE/O levels	7	17.5
No qualifications	33	82.5
Usual occupation		
Clerical/commercial	1	2.5
Skilled manual/non-manual	8	20
Unskilled manual/non-manual	17	42.5
Predominantly unemployed	14	35

3.3 Diagnostic Information

The psychiatric categorisation of the participants within the Special Hospital is presented in Table 3. Although more participants had the legal category of psychopathic disorder, psychotic disorders (legal category, 'mental illness') accounted for over half of the primary diagnoses. Forty percent of the sample had a further psychiatric diagnosis, with a range of disorders being represented. The majority of the sample were held under restriction orders under the Mental Health Act (1983), sections 37/41 or 47/49.

Table 3. Diagnostic characteristics of the sample

	n=40	
	n	%
Primary psychiatric diagnosis		
Psychotic disorder	21	52.5
Unspecified personality disorder	10	25
Anti-social personality disorder	5	12.5
Borderline personality disorder	4	10
Secondary psychiatric diagnosis		
Unspecified personality disorder	6	15
Depression	3	7.5
Borderline personality disorder	2	5
Anti-social personality disorder	2	5
Psychotic disorder	1	2.5
PTSD	1	2.5
Other	1	2.5
None	24	60

3.4 Other Clinically Relevant Information

The majority of the sample were currently involved in 'active' treatment programmes. Fifty eight percent of participants were currently taking psychotropic medication, with almost half of the sample (n=19) being prescribed anti-psychotics. This is consistent with the diagnostic profile. A number of participants were taking more than one type of psychotropic medication.

In addition to pharmacological treatments, all of the participants were receiving or had received psychological therapies.

Three quarters of the sample had been involved in substance misuse beyond 'experimentation', and just over two thirds (67.5%) had a history of alcohol misuse. Over half of the sample (n=23) had attempted suicide to the knowledge of the hospital, with the majority of those (n=16) having made more than one attempt.

3.5 Offending Characteristics of the Sample

Table 4 presents the nature of the index offence[2] of each participant. The vast majority of the sample had been convicted of offences of interpersonal violence, and this is representative of the male Broadmoor population. In addition to the index offence, two thirds of the sample had committed sexual offences, with 30% of participants having offended against children.

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[2] Index offence is the term given to the offence which has led to the person being admitted to the Special Hospital.

Table 4. Offending characteristics of the sample

	n=40	
	n	%
Index Offence		
Murder/manslaughter	11	27.5
Assault/GBH	8	20
Rape of female	5	12.5
Fire setting	4	10
Sexual abuse of minor	4	10
Armed robbery	3	7.5
Robbery/burglary	2	5
Rape of male	1	2.5
Indecent assault	1	2.5
Sexual indecency	1	2.5
History of sexual offences		
Adults only	15	37.5
Children only	6	15
Adults & children	6	15
None	13	32.5

3.6 Other Potentially Traumatising Life Events

In addition to CSI which is discussed below, the participants had extensive experience of other potentially traumatising life events, such as the breakdown/loss of significant relationships and other forms of abuse (physical and emotional). It is however, beyond the scope of this study to report these results in detail.

3.7 History of Disclosed Childhood Sexual Interaction

The sample is characterised by multiple 'episodes' of CSI, with 82.5% of participants having experienced two or more episodes. The mean number of episodes was 2.6 (SD=1.4) and the range was 1 to 8. This means that a large sample of episodes (n=104) was generated, and this has been subjected to separate analysis as presented below.

The mean age of the survivor at the start of these episodes was 7 years 10 months (SD=2 years 11 months), although there is a wide spread of ages, from 2 to 15 years of age.

Although a third (33.6%) of the episodes were of extended duration (a year or longer), almost as many (31.7%) were isolated incidents. Of the extended episodes (n=61), over half (62%) involved frequent or very frequent 'contact' with the perpetrator/partner. Information on duration and frequency was not available for a significant number of episodes.

There was a wide range of age differentials between survivors and perpetrators/partners (from no age difference to a difference of over 48 years), with a mean age differential of 11 years and 6 months (SD=12 years 6 months).

The gender of the perpetrator/partner was split almost equally between male and female, with slightly more men (55.8%). The relationship between each perpetrator/partner and survivor involved in the 104 episodes of CSI are shown in Table 5.

Table 5. The relationship between the perpetrators/partners and survivors

	n=104 %
Mother	2.9
Father	3.8
Sibling	11.5
Other family member	11.5
Friend/schoolmate	19.2
Neighbour	10.6
Teacher/instructor	5.8
Staff in residential unit	5.8
Other known (e.g. family friend)	18.3
Stranger	10.6

There is a broad range of relationships with the perpetrator/partner represented. Parents of either gender are not very highly represented, although other family members make up about a quarter of perpetrators/partners. Other family members include step-mothers and step-fathers. A large proportion of episodes took place with similar aged friends or schoolmates (almost 20%). However, approximately 40% of perpetrators/partners were other people known to the participants, usually adults, and often in positions of authority or power, such as teachers, residential staff members, and family friends. Only around 10% of episodes occurred with a person unknown to the participant.

The information provided on the nature of CSI was used to create dichotomous variables for the purpose of statistical analysis. The dichotomous nature of the variables are a method of reducing the information held across the sample of 104 episodes to reflect the experiences of the 40 participants. These variables indicate whether an individual has each CSI characteristic in their history, and thus they can accommodate multiple episodes.

3.8 Hypothesis Testing

3.8.1 Hypothesis 1 - Statement 1

The first statement of hypothesis 1, that high levels of psychological symptomatology are expected in the Special Hospital sample relative to general population norms, was tested by examining the data derived from the questionnaire-based measures.

3.8.1.1 Scores from Questionnaire-Based Outcome Measures

The mean scores for each questionnaire-based outcome measure (apart from the BSFQ) are presented in Table 6.

The table is split in order to group the measures by whether higher or lower scores indicate greater symptomatology. Higher scores on the TSC and BDI indicate greater presence of symptomatology, i.e. less positive outcome. The total scores for the scales of the TSC represent the frequency with which each of the symptoms are experienced, as indicated by a scale ranging from 0 (never) to 4 (always). The total scores of the sub-scales are not directly comparable because they are derived from differing numbers of items. Therefore, the mean score on the 0-4 symptom frequency scale was

calculated for each sub-scale, so that direct comparisons could be made. The mean score of the frequency scale across all sub-scales was 1.14 (SD=0.57). The sleep disturbance sub-scale had the highest mean of 1.73 (SD=0.99), suggesting greater frequency of sleep disturbance trauma symptoms, followed by depression at 1.30 (SD=0.59), dissociation at 1.16 (SD=0.74) and SATI at 1.08 (SD=0.77). Anxiety and sexual problems trauma symptoms showed the least frequency, with mean scores of 0.90 (SD=0.55) and 0.95 (SD=0.70) respectively.

Higher scores on the WAS represent greater endorsement of the world assumptions (i.e. more positive outcome) as indicated by a scale ranging from 1 (strongly disagree) to 6 (strongly agree). In this case, the total scores obtained for each of the sub-scales are directly comparable as they are all derived from 4 individual items. It can be seen that the 'benevolence of people' is the most highly endorsed world assumption with a mean score of 17.80 (SD=3.51), and 'justice' is the least endorsed with a mean score of 11.47 (SD=3.62).

Higher scores on the CFSEI indicate greater self-esteem (i.e. more positive outcome) as a total score and across the 3 sub-scales, as generated by yes/no responses to each question. The three sub-scales are not directly comparable, as the general scale comprises 16 items, and the social and personal scales comprise 8 items each.

Table 6. Mean scores on questionnaire-based outcome measures

	n=40	
	Mean scores	(SD)
Higher scores = greater symptomatology		
Trauma symptoms (TSC)		
Total score	45.53	(22.98)
Dissociation	6.98	(4.45)
Anxiety	7.17	(4.39)
Depression	11.67	(5.27)
Sexual problems	7.57	(5.63)
Sleep disturbance	10.35	(5.94)
Sexual abuse trauma index (SATI)	8.60	(6.17)
Depression (BDI-II)		
Total score	16.27	(9.69)
Lower scores = greater symptomatology		
World assumptions (WAS)		
Benevolence of impersonal world	15.33	(4.36)
Benevolence of people	17.80	(3.51)
Justice	11.47	(3.62)
Controllability	14.75	(4.45)
Randomness	13.10	(5.12)
Self-worth	15.13	(5.45)
Self-controllability	14.75	(4.85)
Luck	12.25	(5.09)
Self-esteem (CFSEI-2)		
Total score	17.85	(6.83)
General	9.15	(4.07)
Social	5.10	(2.19)
Personal	3.60	(2.27)

The BSFQ revealed that there were high levels of dissatisfaction with the level of current sexual activity, with only a quarter of the sample reporting being satisfied and 55% being dissatisfied. This needs to be considered in the context of the maximum security setting, where sexual activity between patients is prohibited. Nevertheless, almost half of the participants (47.5%) described their level of current sexual activity as 'as much as desired' in this context. Only 3 participants reported that they were involved in more sexual activity than they desired. Almost three quarters of the sample (72.5%) said that no sexual advances had been made towards them in the last month. Of those who had been approached (n=11), most usually refused (n=7), with only one participant saying that he accepted reluctantly.

In contrast, 87.5% of the sample reported being satisfied with the levels of their sexual activity prior to incarceration.

In terms of sexual orientation, almost three quarters of participants (72.5%) described their desires as exclusively heterosexual. However, in terms of actual sexual experiences, considerably more men had been involved in same-sex activities, with only 45% never having had any homosexual contact.

Only 12 participants described themselves as having a sexual problem. A range of problems were represented, as shown in Table 7, but this did include 4 participants describing the heterosexual celibacy enforced by the maximum security context as a sexual problem.

Table 7. Self-disclosure of sexual problems on the BSFQ

	n=40	
	n	%
Self-disclosure of sexual problems	**12**	**30**
Enforced heterosexual celibacy	4	10
Sexual identity confusion	2	5
Paedophilia	2	5
The offending behaviour	1	2.5
Thoughts of offending	1	2.5
Erectile dysfunction	1	2.5

The overall measure of self-reported sexual adjustment produced a mean of 3.77 (SD=1.29). This measure consisted of a scale ranging from 1 (poorly adjusted) to 5 (well adjusted).

3.8.1.2 Comparison of Scores on Questionnaire-Based Outcome Measures With Those Obtained in Other Research Studies

In order to place the results from the questionnaire-based outcome measures in context, comparisons were made with studies using the same measures with other survivor samples, other clinical groups and the general population. Table 8 presents these comparisons. Again, the table is organised to group the measures by whether higher or lower scores indicate more negative outcome: measures where higher scores indicate greater symptomatology are shown first, followed by the measures where lower scores indicate greater symptomatology.

In comparing the extent of trauma symptoms present in the current sample with the male survivors in the research of Mendel (1995), only the overall mean of the scale ranging from 0 (never) to 4 (always) can be utilised. This is because Mendel used the

first version of the scale (TSC-33) in his research, which has 7 fewer items, thereby invalidating the comparison of total scores. When comparing the means of this scale, it can be seen that Mendel's sample indicated a higher overall frequency of trauma symptoms (a mean of 2.61, SD unreported, falling between 'sometimes' and 'very often') than did the sample in the current study (a mean of 1.14, SD=0.57, falling between 'infrequently' and 'sometimes'). However, it was possible to compare total scores on the trauma symptoms measure with those obtained in the research of Binder, McNiel & Goldstone (1996) because both studies used the more recent version of the scale. Binder and colleagues investigated a sample of female survivors who identified themselves as functioning well. It can be seen that these female survivors reported experiencing less frequent trauma symptoms consistently across the different sub-scales than was reported by participants in the current study. Binder and colleagues do not report on the score obtained for the sleep disturbance sub-scale.

The mean total score of the BDI obtained in the current study, at 16.27 (SD=9.69), is higher than the general population mean of 12.56 (SD=9.93), but lower than the psychiatric outpatient sample mean of 22.45 (SD=12.56), as reported in the norms generated by Beck and colleagues (1996). Comparing this mean with another sample of male survivors, it is found to be higher than the mean of 13.40 (SD=10.3) obtained in the research of Sigmon and colleagues (1996).

Satisfaction with the level of current sexual activity is found to be similar to that found in Mendel's (1995) sample (M=4.85, SD=2.32, and M=4.77, SD unreported, respectively). However, Reynolds and colleagues (1988) found higher levels of dissatisfaction in their sample of men with depression, which generated a mean score

of 5.60 (SD=1.6) on the scale ranging from 1 (completely satisfied) to 7 (completely dissatisfied).

The mean scores obtained for two of the WAS sub-scales; 'benevolence of the world' (M=15.33, SD=4.36) and 'self-worth' (M=15.13, SD=5.45), were found to be much higher and thereby indicating greater endorsement of the assumptions than those obtained by Mendel (1995) (M=3.94 & 3.36 respectively, SDs unreported). However, the mean scores for these scales in the current study were not quite as high as those obtained by Janoff-Bulman (1989) with her sample of male and female survivors of incest (M=16.50 & 17.40 respectively, SDs unreported).

The self-esteem scores from the current study were lower than those reported in the general population norms described by Battle (1992). This was consistent across the sub-scales.

In the current study, the mean score of the overall sexual adjustment measure (M=3.77, SD=1.29) was higher than that generated by Mendel's (1995) sample of male survivors (M=2.31, SD unreported), indicating greater perceived sexual adjustment in the current sample.

Table 8. Comparison of mean scores on questionnaire-based outcome measures with those obtained in other research studies

	Present study	Mendel (1995) Male survivors	Binder et al. (1996) Female survivors	Janoff-Bulman (1989) Male & female survivors	Battle (1992) General population	Beck et al. (1996) General population	Sigmon et al. (1996) Male survivors	Reynolds et al. (1988) Depressed men
TSC total	45.53		32.07					
TSC scale mean	1.14	2.61						
TSC dissociation	6.98		4.47					
TSC anxiety	7.17		5.40					
TSC depression	11.67		7.17					
TSC sex problems	7.57		5.47					
TSC SATI	8.60		3.39					
BDI total	16.27					12.56	13.40	
Sexual satisf. now	4.85	4.77						5.60
WAS WB	15.33	3.94		16.50				
WAS self-worth	15.13	3.36		17.40				
SE total	17.85				23.08			
SE general	9.15				11.78			
SE social	5.10				6.62			
SE personal	3.60				4.68			
Sexual adjustment	3.77	2.31						

3.8.2 Hypothesis 1 - Statement 2

The second statement of hypothesis 1, that the presence of psychological symptomatology is expected to be associated with the characteristics of CSI, was tested by focusing upon outcome as represented by questionnaire-based measures.

To begin with, Pearson's Product Moment correlations were run between all variables representing characteristics of the CSI and the scores from each questionnaire measure (including sub-scales), in order to identify any bivariate relationships. Fifteen statistically significant associations between the characteristics of CSI and questionnaire-based outcome measures were found. These associations represent an apparently complex picture, indicating very specific relationships. However, it should be noted that most of the associations are not very strong, with only 2 correlation coefficients reaching statistical significance at the $p<.01$ level.

Stepwise multiple regression analysis was undertaken in order to investigate these associations further. All independent variables were entered into the analysis, as it is understood that correlations between independent and dependent variables cannot always predict the variables selected by multivariate analysis. Missing data were treated in a listwise fashion. Kolmogorov-Smirnov tests applied to the unstandardised residual statistic of each regression revealed that the residuals were normally distributed.

Tables 9(i) and 9(ii) present only the characteristics of CSI (independent variables) which significantly account for any variance in the questionnaire-based outcome measures (dependent variables). It can be seen that the variance in the majority of the

questionnaire-based outcome measures can be partly accounted for by the presence/absence of particular characteristics of CSI. Perpetration by a family member other than parents or siblings is associated with six of the outcome measures: total trauma symptoms score, anxiety and dissociation trauma symptoms, the sexual abuse trauma index, total self-esteem score, and personal self-esteem score. Perpetration by a known person other than family or friends is associated with current sexual satisfaction, overall sexual adjustment, total self-esteem score, and personal self-esteem score. Female perpetration is associated with sexual functioning outcome measures: current sexual satisfaction, past sexual satisfaction, and overall sexual adjustment. Male perpetration is associated with world assumptions: self-worth and justice. Frequency of contact is associated with depression trauma symptoms, and duration of episodes is associated with sleep disturbance trauma symptoms. Perpetration by an unknown person is associated with sexual orientation, and the age differential between survivor and perpetrator/partner is associated with the 'benevolence of people' world assumption.

Multiple correlations between independent variables (characteristics of CSI) were found to exist. The independent variables were checked for collinearity in the regression analysis in order to identify any significant characteristics of CSI which were not shown in the regression equations as a result. Collinearity was found to be relevant to two questionnaire-based outcome measures only. Although not shown in the equation, duration was found to significantly account for 11% ($p<.05$) of the variance in the depression trauma symptoms, and other family member perpetration and the number of interactions accounted for 27% ($p<.01$) of the variance in the sexual orientation measure.

Although the number of independent variables entering the equations was often high in this study (up to 16), the number of actual predictors was low (1-3), which satisfies the predictors to N ratio (Howell, 1992).

Table 9(i). Multiple regression analysis: Characteristics of childhood sexual interactions (independent variables) which account for any of the variance in the questionnaire-based outcome measures (dependent variables)

	B	T	R^2	d.f.	F
TSC total					
- other family member as perpetrator	-21.56	-2.63*	.18	1, 32	6.92*
TSC anxiety					
- other family member as perpetrator	-5.24	-3.46**	.27	1, 32	11.98**
TSC depression					
- frequency	3.97	2.27*	.14	1, 32	5.14*
TSC dissociation					
- other family member as perpetrator	-4.32	-2.73*	.19	1, 32	7.43*
TSC SATI					
- other family member as perpetrator	-5.83	-2.66*	.18	1, 32	6.95*
TSC sleep					
- duration	6.16	2.82**	.20	1, 32	7.97**
Current sexual satisfaction					
- other known person as perpetrator	-2.86	-2.18*	.13	1, 32	4.92*
- female as perpetrator	-1.82	-2.15*	.24		
Past sexual satisfaction					
- female as perpetrator	1.25	2.50*	.16	1, 32	6.27*

* $p<.05$, ** $p<.01$, *** $p<.001$

Table 9(ii). Multiple regression analysis: Characteristics of childhood sexual interactions and constructions of these interactions (independent variables) which account for any of the variance in the questionnaire-based outcome measures (dependent variables) cont./

	B	T	R^2	d.f.	F
Sexual orientation					
- stranger as perpetrator	-1.39	-3.66***	.29	1, 32	13.36***
Sexual adjustment					
- female perpetrator	-1.18	-2.67*	.17	2, 31	7.22**
- other known person as perpetrator	-1.75	-2.57*	.32		
WAS benevolence of people					
- age differential	-3.05	-2.13*	.12	1, 32	4.55*
WAS justice					
- male as perpetrator	-3.03	-2.25*	.14	1, 32	5.07*
WAS self-worth					
- male as perpetrator	7.16	3.99***	.33	1, 32	15.94***
Total self-esteem					
- other family member as perpetrator	4.83	2.06*	.12	1, 32	4.24*
General self-esteem					
- other known person as perpetrator	-5.77	-2.67*	.18	1, 32	7.13*
Personal self-esteem					
- other family member as perpetrator	1.86	2.27*	.14	1, 32	5.14*

* p<.05, ** p<.01, *** p<.001

3.8.3 Hypotheses 2 & 3

The constructions of each disclosed episode and the self-reporting of distress related to these experiences were assessed, and these are presented in Table 10.

Table 10. History of childhood sexual interactions - constructions & self-reported distress

	n=104 %
Construction at the time	
Very bad	29.8
Bad	6.7
Neither good nor bad	16.3
Good	28.8
Very good	18.3
Construction now	
Very bad	19.2
Bad	22.1
Neither good nor bad	26.9
Good	13.5
Very good	18.3
Distress at the time	
Very distressed	31.7
Moderately distressed	5.8
Mildly distressed	7.7
Not at all distressed	54.8
Distress now	
Very distressed	13.5
Moderately distressed	10.6
Mildly distressed	19.2
Not at all distressed	56.7

Almost half of the episodes were described as being experienced positively at the time, although this decreases to just over 30% when considered at the time of interview. A further 16.3% described the experience at the time in neutral terms, and this increased to just under 27%. This supports hypothesis 2, which states that the majority of participants will construct CSI in positive or neutral terms.

There appears to be no real change in the proportion of episodes being reported as causing distress between the time of the interaction and on reflection at the time of interview, with over half of the episodes being described as not causing any distress at both time points. This supports hypothesis 3, which states that the majority of participants will report no distress in relation to their CSI experience.

3.8.4 Hypothesis 4

The hypothesis that no association is expected between psychological symptomatology as assessed by questionnaire measures and the constructions of CSI was first tested by dividing the sample on the basis of whether participants had a negative construction of any of their interactions at the time of CSI (n=23) or only neutral or positive constructions (n=17). The sample was also divided on the basis of whether participants had a negative construction of any of their interactions at the time of interview (n=26) or only neutral or positive constructions (n=14). This allowed for between-group comparisons of psychological symptomatology.

Statistical analysis was undertaken to identify any differences in demographic information between the groups. Independent t-tests revealed no differences between

the groups in age, and chi-squared analysis revealed no differences in the level of education. Chi-squared analysis suggested some differences between the groups in ethnicity; that non-white participants tended to report positive constructions and no distress more often than white participants. However, small expected frequencies (less than 5) in 50% of the cells meant that these results could not be considered reliable. Chi-squared analysis should not be used if 20% or more of the cells have an expected frequency of less than 5 (Bryman & Cramer, 1997).

The choice of test used for comparing the groups on each questionnaire-based outcome measure was determined by the criteria for parametric and non-parametric analysis. Kolmogorov-Smirnov tests applied to the outcome scores in each group revealed that the scores of three of the questionnaire-based outcome measures were not normally distributed. Consequently, non-parametric Mann-Witney U-tests were applied to these three measures: current sexual satisfaction, sexual orientation, and overall sexual adjustment. No significant differences were found on these outcome measures between the negative and positive construction groups. A Mann-Witney U-test was also applied to the sleep disturbance trauma symptom scale because Levene's test for equality of variances revealed unequal variance. No significant difference was found between the groups on this measure. The scores on the remaining questionnaire-based outcome measures were found to be normally distributed and of equal variance between the groups, and thus they were suitable for parametric analysis. Independent t-tests revealed no significant differences between groups.

Hypothesis 4 was further tested through multivariate analysis in order to determine whether the constructions would account for any of the variance in the

symptomatology measures when in combination with the variables related to the characteristics of CSI. First, Pearson's Product Moment correlations between the scores from the questionnaire measures and the scores from the construction scales were examined, in order to identify any bivariate relationships. Only one significant correlation coefficient was found. The construction held at the time of CSI was found to correlate with the frequency of sleep disturbance trauma symptoms ($r=-.3187$, $p<.05$).

The constructions held at the time of CSI and at the time of interview were added as independent variables to the stepwise multiple regression analysis previously undertaken with the characteristics of CSI as independent variables and the questionnaire-based outcome measures as the dependent variables. This was done in order to determine if the constructions would further contribute to any of the regressions previously calculated. This analysis was found to fulfill the criteria for normal distribution. The construction variables were found to contribute to only three of the regressions and these results are shown in Table 11. When construction at the time of interview was added to the analysis, it increased the 12% ($p<.05$) of variance in the 'benevolence of people' world assumption scale accounted for by age differential alone to 29% ($p<.001$). It also accounted for 12% ($p<.05$) of the variance in social self-esteem alone. When construction at the time of CSI was added, it increased the 14% ($p<.05$) of variance in the 'justice' world assumption scale accounted for by male perpetration alone to 25% ($p<.05$). The analyses were checked for further collinearity, but none was found to be relevant to the regressions.

Table 11. Multiple regression analysis: Characteristics of childhood sexual interactions **and constructions of these interactions** (independent variables) which account for any of the variance in the questionnaire-based outcome measures (dependent variables)

	B	T	R^2	d.f.	F
WAS benevolence of people					
- age differential	-4.04	-2.98**	.12	2, 31	6.38**
- construction now	3.18	2.71*	.29		
WAS justice					
- male as perpetrator	-4.16	-3.02**	.14	2, 31	5.14*
- construction at the time	2.56	2.15*	.25		
Social self-esteem					
- construction now	1.57	2.12*	.12	1, 32	4.49*

* p<.05, ** p<.01, *** p<.001

3.8.5 Hypothesis 5

The hypothesis that no association is expected between the self-report of distress and questionnaire-based outcome was first tested by dividing the sample on the basis of whether participants reported distress at the time of any of their CSI's (n=28) or reported no distress at the time of CSI (n=12). The sample was also divided on the basis of whether participants reported distress at the time of interview relating to any CSI (n=26) or reported no distress at the time of interview (n=14). This allowed for between-group comparisons of psychological symptomatology as assessed by questionnaire measures. Kolmogorov-Smirnov tests applied to the outcome scores in the distress at the time of CSI group revealed that the scores of three of the questionnaire-based outcome measures were not normally distributed. Consequently, non-parametric Mann-Witney U-tests were applied to these three measures: current

sexual satisfaction, past sexual satisfaction, and sexual orientation. A non-parametric Mann-Witney U-Test was applied to the sexual orientation measure for the distress at the time of interview groups, for the same reasons. No significant differences were found on these outcome measures between the distress groups.

The scores on the remaining questionnaire-based outcome measures were found to be normally distributed and of equal variance between the groups, and thus they were suitable for parametric analysis. Independent t-tests revealed only a small number of significant differences between groups. There was a small significant difference in endorsement of the 'benevolence of the world' assumption between the distress at the time of CSI groups ($t=-2.16$, $d.f.=38$, $p<.05$). The group which reported no distress at the time of CSI had a higher mean score ($M=17.5$, $SD=3.8$) on this assumption scale than the group which did report distress at the time of CSI ($M=14.4$, $SD=4.3$). There were significant differences in the mean scores of three of the trauma symptoms scales between those that reported distress at the time of interview and those who reported no distress. The group that reported distress had a mean score of 8.3 ($SD=4.4$) on the anxiety scale, and the group that reported no distress had a mean score of 5.1 ($SD=3.7$) ($t=2.35$, $d.f.=38$, $p<.05$). The distress group had a higher mean score ($M=12.9$, $SD=5.2$) on the depression scale than the no distress group ($M=9.4$, $SD=4.7$) ($t=2.06$, $d.f.=38$, $p<.05$). The distress group also had a higher mean score ($M=8.2$, $SD=4.5$) on the dissociation scale than the no distress group ($M=4.7$, $SD=3.6$) ($t=2.51$, $d.f.=38$, $p<.05$).

Again, hypothesis 5 was further tested by examining Pearson's Product Moment correlations between the two distress scales and all of the questionnaire-based

outcome measures, in order to identify any bivariate relationships. Only four significant correlations coefficients were identified. Three of these were between distress reported at the time of interview and trauma symptoms: dissociation ($r=-.3774$, $p<.05$), anxiety ($r=-.3561$, $p<.05$), and depression ($r=-.3168$, $p<.05$). Distress reported as experienced at the time of CSI was significantly correlated with the 'benevolence of the world' assumption ($r=.3309$, $p<.05$).

The self-reported distress at the time of CSI and at the time of interview were added as independent variables to the stepwise multiple regression analysis previously undertaken, with the characteristics of CSI as independent variables and the questionnaire-based outcome measures as the dependent variables. This was done in order to determine if self-reported distress would further contribute to any of the regressions previously calculated. This analysis was found to fulfill the criteria for normal distribution. The distress variables were found to contribute to five of the regressions and these results are shown in Table 12. When distress at the time of interview was added to the analysis, it increased the 18% ($p<.05$) of variance accounted for in the total TSC score to 31% ($p<.01$), the 27% ($p<.01$) of variance accounted for in the TSC anxiety scale to 41% ($p<.001$), the 14% ($p<.05$) of variance accounted for in the depression TSC scale to 38% ($p<.01$), and the 19% ($p<.05$) of variance accounted for in the dissociation TSC scale to 34% ($p<.01$). When distress at the time of CSI was added, it accounted for the variance in only one questionnaire-based outcome measure. It accounted for 29% ($p<.01$) of the variance in the 'benevolence of the world' assumption scale, along with father as perpetrator.

The analyses were checked for further collinearity, but none was found to be relevant to the regressions.

Table 12. Multiple regression analysis: Characteristics of childhood sexual interactions and **self-reporting of distress** (independent variables) accounting for any of the variance in the questionnaire-based outcome measures (dependent variables)

	B	T	R^2	d.f.	F
TSC total					
- distress now	-18.42	-2.44*	.19	2, 31	6.98**
- other family member as perpetrator	-18.36	-2.37*	.31		
TSC anxiety					
- other family member as perpetrator	-4.60	-3.27**	.27	2, 31	10.73***
- distress now	-3.67	-2.68*	.41		
TSC depression					
- distress now	-4.20	-2.65*	.19	3, 30	6.15**
- frequency	4.04	2.55*	.29		
- other known person as perpetrator	5.56	2.11*	.38		
TSC dissociation					
- distress now	-3.88	-2.71*	.21	2, 31	8.14**
- other family member as perpetrator	-3.64	-2.48*	.34		
WAS benevolence of the world					
- distress at the time	5.05	3.29**	.19	2, 31	6.40**
- father as perpetrator	-4.38	-2.09*	.29		

* p<.05, ** p<.01, *** p<.001

3.8.6 Hypothesis 6

The hypothesis that an association is expected between the self-reported experience of distress related to CSI and the constructions of these interactions was tested by examining Pearson's Product Moment correlations between the scores from the distress scales and the scores from the construction scales, in order to identify any bivariate relationships.

The sample used in this analysis was the total number of episodes (n=104). This was possible because the constructions scores and self-reported distress scores were obtained for each episode experienced, unlike the questionnaire-based outcome measures, which were obtained for each participant. It should also be noted that lower scores on the construction scales indicate more negative constructions and lower scores on the distress scales indicate higher levels of self-reported distress. Table 13 presents the correlation coefficients obtained.

Table 13. Significant correlation coefficients between constructions of childhood sexual interactions and self-reporting of distress

	Construction at the time	Construction now
Distress at the time	.8741***	.6417***
Distress now	.6183***	.7651***

* p<.05, *** p<0.001

It can be seen that there are very strong associations. More positive constructions were associated with lower levels of distress, reported for both the time of CSI and the time of interview.

4.0 DISCUSSION

The discussion will begin with an overview of the research findings and issues of methodology. The results will then be discussed in the light of previous research. The clinical implications of the research findings will be outlined, followed by suggestions for future research. Finally, the overall conclusions from this study will be presented.

4.1 Aims of the Study

The two main aims of this study were: (i) to survey a forensic population of men who had experienced CSI, to determine the profile of sequelae related to these experiences; (ii) to examine the relationship between constructions of these experiences and the related self-report of distress, and outcome as represented by psychological symptomatology assessed by questionnaire measures.

4.2 Summary of Research Findings

4.2.1 The Nature of Childhood Sexual Interaction

Over 80% of participants in this sample had experienced two or more episodes of CSI. There was a range of ages at which CSI commenced, with one participant as young as two years old. Many isolated incidents of CSI were disclosed, although a significant proportion were episodes of extended duration and involved frequent 'contact'. The gender of perpetrators/partners split almost evenly between male and female, and a range of relationships were represented, with family members (other than parents), friends and schoolmates, and other known adults making up the majority.

The mean age differential of 11 years 6 months suggests that a large number of episodes involved an age differential which, if guided by the existing literature, would define the interaction as 'abusive'. For instance, many studies have defined CSI with an age differential of 5 years or more as 'abusive' (e.g. Briere & Runtz, 1988). In fact, 80% of participants had experienced at least one CSI with an age differential of 5 years or more.

4.2.2 Demographic & Other Background Information

The sample comprised mostly white, unqualified and unskilled men with a range of psychiatric diagnoses. This is largely representative of the male Broadmoor population (Dell & Robertson, 1988). Over half had the primary diagnosis of a psychotic disorder, the remainder having diagnoses of personality disorder. However, two thirds of the sample had the legal category of psychopathic disorder. There was a very high prevalence of substance and alcohol misuse, and suicide attempts in the histories of the participants. Most had been convicted of offences of interpersonal violence, and two thirds had committed sexual offences. Almost a third had sexually offended against children.

4.2.3 The Profile of Psychological Functioning

The first statement of hypothesis 1, that high levels of psychological symptomatology would be found in the sample, was supported. Trauma symptoms were found to be experienced more frequently by participants in this study, than as reported by a sample of well-functioning female survivors, with sleep disturbance trauma symptoms being the most frequent. Depression related trauma symptoms were the next most frequent

trauma symptoms, and symptoms of depression as measured by the BDI-II were more severe than indicated for general population norms. Assumptions about the benevolence of the world were the most strongly endorsed, and assumptions about luck and justice the least endorsed. However, where comparisons were possible, assumptions about world benevolence and self-worth were less strongly endorsed than a sample of male and female survivors of incest. Self-esteem was lower than population norms across all scales. The finding that considerably more men reported having experienced same-sex sexual contact than those reporting that they desired it perhaps suggests some confusion over sexual identity. Although perhaps lower than expected, a significant proportion of the sample reported experiencing sexual problems.

The symptomatology assessed through questionnaire-based measures was shown to be associated with CSI, in as much as the levels of symptomatology varied to some extent with the variations in the characteristics of CSI. This finding supported the second statement of hypothesis 1. The relationships between characteristics of CSI and questionnaire-based symptomatology measures were found to be numerous and very specific. Factors relating to the relationship with the perpetrator/partner and gender of the perpetrator/partner were found to have the most associations with symptomatology as assessed by questionnaire-based measures. The frequency and duration of CSI and the age differential between survivor and perpetrator/partner were also found to have associations with the outcome measures. However, no single characteristic was found to be consistently associated with the range of questionnaire-based outcome measures.

The participants' constructions of CSI and self-reported distress related to these experiences supported hypotheses 2 and 3. The majority of episodes were described as being experienced at the time of the interactions as positive or neutral, although this decreased a little when considered at the time of interview. However, there was an increase in the number of participants viewing these interactions neutrally, but most of the shift appears to be explained by participants being less likely to construct their experiences in positive terms at the time of interview than they did as children or adolescents. There appeared to be no real change in the proportion of episodes being reported as causing distress between the time of the interaction and on reflection at the time of interview, with over half of the incidents being described as causing no distress.

There was a very close relationship between the constructions of CSI and the level of self-reported distress related to these experiences, as predicted by hypothesis 6. However, there was very little relationship between the constructions of CSI and the level of symptomatology as assessed by questionnaire-based measures. Constructions of CSI were only associated with three of the questionnaire-based outcome measures, and only one significant difference was found in the levels of symptomatology as assessed by questionnaire-based measures between those who had ever constructed CSI negatively and those who only constructed CSI positively or neutrally. Although hypothesis 4, which states that no association would be found, was not fully supported, it is clear that self-reported distress is much more closely associated with constructions of CSI than symptomatology assessed by questionnaire-based measures in this sample.

Indeed, no association was expected between self-reported distress and symptomatology as assessed by questionnaire-based measures, as predicted by hypothesis 5. Again, although this hypothesis was not supported, self-reported distress was slightly associated with only five of the questionnaire-based outcome measures, four of which were trauma symptom measures.

4.3 Methodological Issues

4.3.1 The Sample

The sample is relatively small and drawn from a highly select and specific population, and so the generalisability of the findings to the wider population of male survivors is reduced. The response rate of those approached was good. Of course, the sample is biased by information only being gathered from those patients who agreed to participate. This can be a particularly significant factor in forensic settings. Megargee (1995) refers to Nelson (1981) who demonstrated that offenders who volunteer to participate in research differ systematically from those who do not.

The sample is also biased by the inclusion of only patients who had previously disclosed CSI. In addition, there may be undisclosed interactions in the histories of the participants. This would weaken the findings, especially the analysis of associations between characteristics of disclosed CSI and symptomatology. This may explain the small number of strong associations found in this analysis.

The sample is also restricted to survivors who have had or are having pharmacological and psychological treatments, and to those patients who were considered 'well' enough to be approached for participation.

This study relied heavily on participants' self-report. This produces a degree of potential unreliability for several reasons. As previously discussed, male self-report and disclosure can be suppressed by a number of factors, despite accommodation within the design to reduce the impact of these. The degree of 'psychopathology', and thought disorder in particular, could reduce the reliability of information. Goff and colleagues (1991) suggest that people with psychotic disorders tend to under-report experiences such as CSI. On the other hand, people with depression tend to have a negative memory bias which produces greater accessibility to negative memories (Brewin, 1998) and negative cognitive schemas are understood to affect self-report by distorting and categorising life events (Young, 1990). There is the further consideration of 'recovered memories' (Andrews, Morton, Bekerian, Brewin, Davies & Mollon, 1995). The self-report of offenders has also been found to be unreliable and sometimes influenced by 'cross-fertilisation' in settings where symptomatology and traumatic life histories are very prevalent. There is often a high degree of caution present among patients regarding the disclosure of personal information and frequently an externally induced motivation to distort self-report (Heilbrun, 1992).

4.3.2 The Design

Further, the reliance on retrospective data, often going back many years and including memories of very traumatic events, could have reduced the reliability of the information analysed. As Roesler & McKenzie (1994) state, 'as is the case with many

other studies based on memories of events experienced many years in the past, one must recognize that many factors may have intervened to change the nature of the reporting given in the present' (p.150). The lack of a suitable control group or an appropriate comparison group, for the reasons already discussed, limit the conclusions that can be drawn from the study. The questionnaire-based outcome is global, in the sense that it was not related specifically to CSI. This means that many factors in the history of participants could be associated with this outcome, including other traumatic life events. Also, it would mean that at least some discrepancy would be expected between symptomatology assessed by questionnaire measures and self-reported distress, the latter being specifically related to CSI. However, the questionnaire-based outcome measures used were selected because they assess many of the symptom groups that have previously been found to be associated with experiences of sexual abuse in childhood.

4.3.3 The Procedure

Again, although efforts were made to facilitate disclosure, the presence of the researcher may have suppressed self-report and disclosure to some degree. Ussher & Dewberry (1995) note that face-to-face interviews may particularly suppress the disclosure of the more 'taboo' interactions, such as those between family members. This may explain the low prevalence of reported parental perpetration in this study. It is also interesting to note that no participants took up the opportunity to meet again with the researcher for debriefing. The reasons for this are unknown. The challenges for the researcher of examining such sensitive and difficult issues also need to be recognised, including the dangers of 'vicarious trauma' (Courtois, 1994).

4.3.4 The Definitions

It should be noted that although the research design necessitated the avoidance of definitions of 'abuse', the very broad inclusion criteria used may have disadvantages. For instance, the power of any statistical relationships identified, particularly when examining associations between the characteristics of CSI and questionnaire-based outcome, may have been reduced by the inclusion of CSI which was not considered abusive by the participants. This may be particularly true of same or similar age interactions. However, as stated, assumptions cannot be made about how these interactions are experienced, and their numbers are limited in this study anyway.

4.3.5 The Measures

The total number of measures used was limited by the need not to overburden participants, and this means that not all the possible sequelae were assessed. Similarly, the assessment of constructions and self-reported distress was limited. In addition, not all of the measures had undergone comprehensive psychometric evaluation. Indeed, Quayle & Moore (in press) question the applicability of some standardised measures in the 'highly abnormal special hospital setting' because they contain items irrelevant to the patients' lives. In the current study, this was found to be particularly true of the assessment of sexual functioning, which contained a number of questions about sexual activity that seemed to irritate participants. Standardised measures allow comparisons with the general population, but the relevance of such comparisons also has to be questioned.

4.3.6 The Analysis

The number of variables and statistical tests used was high, which increased the chance of Type I errors. In order to reduce this chance, it would be prudent to consider only those results significant at the $p<.01$ level as truly significant. This would reduce the power of the results presented, although the relationships described would still be suggested. This means that conclusions need to be cautious.

The power of the analysis may have been reduced by the level of data reduction necessitated by the research design. Analysis relied heavily on dichotomous variables to summarise participants' histories of CSI, which were often detailed and complex. They were also used to summarise participants' reactions to their experiences, where necessary. Many of the subtleties and much of the detail of this information will have been lost. The extent of missing data in a small number of the variables summarising the characteristics of CSI may have added to this problem. In addition, potentially important information about the nature of CSI was not collected, such as the nature of the sexual activity, whether physical force or threat was used and so on. This information was not used in analysis because details of the interactions were not sought for the reasons previously discussed. This information was sometimes volunteered, but not consistently enough to be entered into analysis. In addition, the examination of group means may overlook important information about individual differences.

4.4 Interpretation of Research Findings

4.4.1 Theoretical Implications

4.4.1.1 The Nature of Childhood Sexual Interaction

The nature of CSI described by this sample is largely consistent with reports from other male survivor populations. Multiple incidents are typical of male populations. Mendel (1995) reports this as the norm in his study, with a mean of 2.34 separate abusers (the mean was 2.6 in the current study). This is consistent with several studies which have found that boys are more likely than girls to be abused by more than one person (e.g. Faller, 1989; Neilsen, 1983).

The age at onset of CSI in the current study, with a mean of 7 years 10 months, is also consistent with other reports of male survivors. In his summary of the literature, Mendel (1995) concluded that almost all studies have found the mean age at onset to be between 7 and 10 years old. The mean in this study is very close to the lower end of this range, however.

The myth has been dispelled that boys are predominantly abused by strangers. In the vast majority of cases the perpetrator is known to the boy before the CSI takes place (e.g. Metcalfe et al., 1990). The current findings are consistent with this, with only 10.6% of episodes involving strangers.

The literature has produced mixed results when extra- and intra-familial abuse between boys and girls has been compared. Mendel (1995) concludes that it appears

that boys are more likely than girls to be victimised by non-family members, with a high proportion of extra-familial abuse taking place. The findings of the current study are consistent with this, with almost three quarters of the episodes occurring outside of the family. Further, Mendel (1995) refers to Grayson (1989) who noted that a significant difference between boy and girl victims was the lower rate of perpetration by the natural father. Again, the current findings were consistent with this, with only 4 episodes involving perpetration by the natural father. However, as discussed, the face-to-face approach of the interview may have suppressed the disclosure of these more 'taboo' interactions.

Several researchers have found high percentages of adolescent perpetration among male victims (e.g. Ramsey-Klawsnik, 1990; Spencer & Dunklee, 1986). Rogers & Terry (1984) found that 56% of male victims had been abused by juvenile perpetrators, as opposed to 28% of girls. There is certainly a high proportion of same or similar age perpetrators/partners in the current study. For example, 37 of the perpetrators/partners were aged under 16. However, this may well be due, at least in part, to the definitions of CSI employed.

The finding that almost half of the perpetrators/partners were female is in line with the increasing realisation of the extent of female perpetration, although again, this figure may also have been increased by the definitions used. Indeed, variation in definitions used in the literature mean that prevalence figures of female perpetration are mixed. However, many studies have found high prevalence rates. Fromuth & Burkhart (1989) found 72% of the male college students in their sample had had a female involved in their abuse. Mendel's (1995) sample reported 60% female perpetration.

It is possible to conclude in general terms that this psychiatric and offending population does not appear to differ greatly in terms of the nature of CSI from other male survivor populations.

4.4.1.2 Demographic & Other Background Information

It has been suggested that psychiatric diagnoses can be considered as sequelae to childhood sexual abuse, and this includes diagnoses of psychotic disorder (Goff et al., 1991) and personality disorder (Jehu, 1992). Of course, it is not possible to draw such conclusions from this study because all participants, by definition, had psychiatric diagnoses. However, it is notable that 40% of the sample had a further, secondary psychiatric diagnosis. Also, it is noteworthy that the legal category of psychopathic disorder appears to be over-represented in the current sample. Taylor (1997) reports that the proportion of patients with psychopathic disorder in the Special Hospitals has been a consistent 25%. In the current sample, 67.5% had this label, although this does include 12.5% with the additional label of mental illness. This may be due to the exclusion of patients who were floridly psychotic from the sample. However, it also possibly suggests that in this population, there is a stronger link between CSI and personality disorder, than with mental illness.

Similarly, offending behaviour has been understood in terms of CSA sequelae (Heads et al., 1997). Again, all participants by definition had offending histories, although the proportion of those interpersonally and sexually offending were high. Indeed, 30% of index offences in the current sample were of an overt sexual nature, whilst Taylor (1997) reports a range of 7-16% of the male population of Broadmoor from 1986-

1994 committing sexual index offences. Sexually offending against children in particular has been linked to offender histories of victimisation in childhood (Groth, 1979a&b), and almost a third of this sample had committed such offences. In addition, substance abuse and suicidal behaviour have been proposed as sequelae to CSA (Watkins & Bentovim, 1992), and these are highly represented in this sample.

4.4.1.3 Hypothesis 1

The nature of the population from which the sample was drawn means that high levels of this kind of symptomatology will be present, possibly regardless of experiences of CSI. Nevertheless, there is some indication that the prevalence of such symptomatology is elevated, particularly a label of psychopathic disorder and a history of sexual offending.

A more comprehensive assessment of symptomatology which has been shown to be related to the experience of CSI was undertaken in order to examine such associations in the current sample. The high levels of this symptomatology in the current sample are largely consistent with other survivor populations, however. The profile of psychological functioning suggests elevated levels of trauma symptoms and depression, and low self-esteem. Endorsement of assumptions about world benevolence and self-worth was less than for a sample of male and female survivors. There was some indication of the presence of sexual problems. However, the extent of sexual problems was perhaps less than expected. Roesler & McKenzie (1994), for example, found high levels of sexual dysfunction in men. However, it is likely that the context of incarceration cannot provide an accurate picture of participants' 'normal' sexual functioning, especially as their levels of sexual activity appear to be greatly

suppressed. In addition, the face-to-face nature of the interview procedure may well have reduced the level of disclosure around this sensitive topic. This could also be explained by a possible lack of insight into such problems, and this could well have been a contributing factor in any sexual offending, the prevalence of which is high in this sample.

It should also be noted that whilst the total score on the BDI-II was higher for this sample than for general population norms and indeed, a sample of male survivors, it was lower than a sample of psychiatric outpatients. This interesting finding may be related to the therapeutic environment and intensive treatment programmes that Broadmoor patients experience.

Indeed, it is interesting that the profile of psychological functioning of the current sample is largely in line with other survivor populations because, as stated, the sample is drawn from a very atypical population. The impact of the external environment is important: 'By definition specific interventions in a special hospital are set in a context of incarceration, which is, in itself, a massive intervention that affects every aspect of the person's life for extended periods of time' (Quayle & Moore, in press, p.4). However, it should be noted that the samples of survivors used for comparison in this study have also largely been drawn from clinical populations, which have often actively been involved in treatment (e.g. Mendel, 1995).

The symptom measures were selected because they assessed the symptomatology that has been found to be associated with the experience of CSA, and theories of the mechanisms of the impact of CSA have grown out of these findings, as previously

discussed. The current study found a similar profile of symptomatology, and so some support for these models is provided. The presence of PTSD-type symptoms is certainly confirmed, and the findings relating to the world assumptions give some support to the schema-based cognitive theory. Many of the emotional, cognitive and behavioural outcomes related to the traumagenic dynamics model are also indicated. These include: lowered self-esteem, substance and alcohol misuse, suicide attempts, shame and guilt, depression, vulnerability to subsequent victimisation and perpetration, aggressive sexual behaviour, and perhaps some sexual identity confusion. A sample of the more qualitative information gathered would help to illustrate this (the quotes presented in this study are a close representation of the verbatim data):

'I felt it was something to do with me, like my personality...I thought; am I sexually attracting these people without knowing it, or do I enjoy being sexually abused? Utter shamefulness made me clam up.'

(CSI at age 9, perpetrator was a male teacher aged approximately 30).

'I didn't mind him touching me and holding me. It confused me about what I was - I'd heard horrible stories about men grabbing boys, but I was OK with it.'

(CSI at age 13, perpetrator was a male stranger aged 19).

A large number of specific characteristics of CSI were found to be associated with a number of the questionnaire-based outcome measures, although these associations were often not strong. Fromuth & Burkhart (1989) found similar results; a number of small but statistically significant relationships. They concluded that men who were

sexually abused are slightly less well adjusted than the nonabused men. This suggests some support for the second statement of hypothesis 1; that psychological symptomatology would be associated in some way with the characteristics of CSI. Briere & Runtz (1988) found a very similar number of associations and at similar significance levels. They concluded that the presence of significant covariation between specific abuse characteristics and subsequent problems adds support to the notion that the abuse plays a role in later psychological symptomatology. In this study, factors relating to the relationship with the perpetrator/partner and gender of perpetrator/partner were found to have most associations with questionnaire-based outcome. The frequency and duration of episodes, and age differential were also found to have associations.

However, the associations appear to indicate some very specific relationships, and not all of them are easy to explain. For instance, male perpetration appears to be associated with greater endorsement of the 'justice' world assumption, and greater self-reported sexual adjustment appears to be associated with a higher number of episodes of CSI. However, most of the associations appear to be more logical. Greater duration and frequency of episodes, and perpetration by a family member appear to be associated with increased symptoms of trauma; and these are similar to the findings of Mendel (1995). Perpetration by a family member is also associated with lower self-worth assumptions and lower personal self-esteem. A lower age differential is associated with greater endorsement of the 'benevolence of people' assumption. Higher sexual adjustment appears to be associated with perpetration by a known person outside the family, and perpetration by females. This kind of perpetration may represent the more 'normal' sexual interactions of childhood and adolescence, and

hence the greater sexual adjustment. Similarly, this kind of perpetration appears to be associated with less current sexual satisfaction, which may have a link with more fulfilling past sexual activity, increasing current frustration. Indeed, higher past sexual satisfaction appears to be associated with female perpetration.

There are also a number of factors which appear to relate to sexual orientation. Although not considered a symptom, Mendel (1995) included the assessment of homosexuality in his study because it has been found to be over-represented in male survivor populations in previous research (e.g. Johnson & Shrier, 1987). In this study, a greater frequency of homosexual orientation was found to be associated with perpetration by a stranger, higher numbers of episodes, and less perpetration by family members and females. These factors may represent a certain amount of 'normal' homosexual activity in childhood or adolescence. On the other hand, homosexual orientation may increase vulnerability to exploitation in certain situations (Lew, 1990).

There are perhaps some clues here to the kinds of CSI which are less associated with long-term psychological effects, such as perpetrators/partners who are female and not members of the family, involving a lesser age differential, and interactions which are of lesser duration and frequency. These kind of interactions may represent more 'normal' sexual activity, but at this point, these assumptions cannot be made, especially as experiences on an individual level have not been comprehensively studied. Also, the interactions between factors have not been examined. It may be the case that female perpetration is only associated with lesser symptomatology when it is also outside of the family.

It is important to stress that a causal relationship between the experience of CSI and the proposed long-term effects is not proven by the current study. It is not possible to identify causal relationships using the data and analysis available for this research. Cahill and colleagues (1991) refer to Briere & Runtz (1987) who draw attention to this fundamental problem: '...it is not clear whether the former [symptomatology in adulthood] is caused by the latter [earlier sexual abuse], or whether both are actually a function of some third variable, such as dysfunctional family dynamics' (Briere & Runtz, 1987, p.51).

The overall picture of a complex and specific set of relationships suggested in this study is largely consistent with previous research (e.g. Roesler & McKenzie, 1994; Williams, 1991; Kelly & Gonzalez, 1990). All of these studies found that earlier age at onset of CSI was associated with greater symptomatology, and this serves to highlight the lack of consistency about the specific relationships in this area of research. This particular relationship was not found in the current study, and a number of other studies have also failed to find this association (e.g. Friedrich, Beilke & Urquiza, 1988; Urquiza, 1988). Mendel (1995) did find this association, along with many others. If these factors are important, this may explain the severity of the symptoms reported in Mendel's study. For instance, his sample had a young mean age at onset of 5 and a half years, and the duration of abuse was high, with a mean of 6 years.

It is interesting to note that the extent to which independent variables were correlated with dependent variables did not always predict which independent variables were

selected by the multivariate analysis as contributing to the regression equations. Ussher & Dewberry (1995) advocate the use of multivariate analysis for this reason: '...it is clear that the use of univariate analysis of the relationship between concomitants of abuse and effect may result in misleading conclusions concerning the factors which will most accurately predict trauma, because many of the predictor factors are interrelated' (p.188).

4.4.1.4 Hypotheses 2 & 3

There is clearly strong support for hypotheses 2 and 3, since the larger proportion of participants reported positive or neutral constructions of CSI and over half reported no distress at all relating to the interactions at both time points. This is consistent with previous research with male survivors (e.g. Baker & Duncan, 1985), and indeed with men in general (e.g. O'Brien, 1994), which suggests that men are less likely to report psychological distress, or to attribute negative meanings to early sexual experiences. However, the true complexity and individuality of men's responses to CSI, and especially the way that these can change over time, is best illustrated by the words of one of the participants. He was involved in sexual activity from the age of 5 until the age of 10, with a male perpetrator who was in his early 20's when the interaction started, and was unknown to the boy prior to this. The participant reported a positive construction at the time of the interaction, but at the same time reported distress relating to the interaction:

> *'It felt mildly good at the time. He was showing me the love I needed as a kid. He kept giving, I kept taking.'*

'I felt distressed at the time because I thought; if this is affection, how come my parents aren't doing it to me? Maybe they're doing it to my brother and sister and not to me. So why not me?'

However, he reported a negative construction of the CSI at the time of the interview, but no longer any distress related to the experience.

'I feel it was bad now because of the experiences it put me through. It screwed up my life.'

'I've been told here that it wasn't my fault, that he took advantage of me. It doesn't cause distress now.'

It should be noted that these responses were unusual, as the constructions and report of distress at one time point tended to be strongly related. However, they do illustrate the complexity of the information gathered, and the possible change in constructions and report of distress over time.

4.4.1.5 Hypotheses 4 & 5

It could be argued that it seems likely that those participants not reporting distress or negative constructions may be those with few long-term effects from their experiences. However, hypotheses 4 and 5 predicted that this would not be the case. Certainly, the generally elevated levels of symptomatology found in the sample, despite the lower levels of self-reported distress and negative constructions, would suggest that the prediction is accurate. When these hypotheses were tested by dividing

the sample on the basis of whether participants reported any distress or not, and on whether they had ever held any negative constructions of CSI or not, the predictions were largely supported. These groups were examined to identify any differences in symptomatology, and very few differences were apparent. When differences were found, they tended to indicate that the group reporting distress at the time of interview were likely to experience a higher frequency of trauma-related symptoms.

When hypotheses 4 and 5 were tested further by examining any associations between the reporting of distress and the nature of constructions held, and the symptomatology assessed by questionnaire measures, only a small number of associations were found. The self-reporting of distress showed slightly more associations with questionnaire-based outcome than constructions. This was explained by the relationship between the current reporting of distress and the presence of trauma symptoms. When current report of distress was added to the multiple regression analysis, it accounted for very significant proportions (along with the nature of the relationship to the perpetrator) of the variance in the total trauma symptoms score, and anxiety, depression, and dissociation trauma symptom scores. It appears that a family member as perpetrator has a strong relationship with current trauma symptoms and self-report of distress. This is the closest relationship found between self-report of distress and questionnaire-based indicators of symptoms. It is possible that the men in this sample more readily equate trauma-related symptoms to psychological distress. The possible reasons for this are unknown, but they may relate to the levels of processing, suggested by O'Brien (1994). She suggests that the criterion for problem recognition may be set at different levels for men and women. It is possible that because the trauma symptoms

are more accessible on a physiological and behavioural level, as opposed to affective or cognitive, men more readily process them.

Overall, although hypotheses 4 and 5 were not completely supported, in as much as associations were found, the level of association was low.

4.4.1.6 Hypothesis 6

A very close relationship was found between the constructions and the more subjective, self-reported distress related to these experiences. This supported hypothesis 6. More positive constructions were associated with lower levels of distress, reported at both the time of CSI and the time of interview. It is not possible in this study to determine the direction of these relationships.

In summary, it appears that psychological symptoms associated with the characteristics of CSI are present across the sample, with little relationship to the self-reporting of distress or the nature of the constructions of CSI. The exception to this is the seemingly more accurate reporting of distress as related to trauma symptoms. The general finding is consistent with the small amount of previous research conducted (Mendel, 1995; Fromuth & Burkhart, 1989; Baker & Duncan, 1985), which has suggested that despite men reporting less distress and more positive experiences, their childhood sexual interactions are still negatively associated with later psychological adjustment. These findings suggest support for theories which stress the importance of considering male socialisation when trying to understand the impact of CSI on men.

It is important to note, however, that the analysis undertaken does not take account of individual differences in experiences. It could be argued that at least for some participants, the reporting of little distress and positive constructions may be related to lesser symptoms and 'non-abusive' CSI, as defined by the existing literature. However, it was not possible to test this hypothesis in this study whilst still avoiding the adoption of predetermined 'abuse' definitions.

4.4.2 Clinical Implications

Bearing in mind the history of attitudes to the sexual abuse of men, one of the most pertinent implications may be the importance of validating men's experiences (Lisak, 1993). Briere & Runtz (1987b) stress that because of the prevalence of CSA, clinicians must be routinely vigilant to the possibility of unresolved sexual abuse trauma in people using mental health services. They claim that clinicians are unlikely to ask about sexual abuse routinely, or may discount or disbelieve their clients' disclosures. This is perhaps particularly pertinent to male populations, where prevalence rates are probably high, but attitudes towards male victimisation remain biased. This situation is likely to be exacerbated in male forensic settings, where prevalence rates are probably higher. However, the findings of the current study would suggest that asking men about experiences of sexual abuse, or indeed CSI which they found distressing or negative, would underestimate and ignore many interactions which may well be significant to their psychosexual development and adult psychological functioning. Extended assessment and detailed history-taking are the norm in forensic settings of course, but how they are approached determines the information received. Clinicians' assumptions and definitions of what constitutes abuse must be avoided. Gartner (1997b) stresses that clinicians must take into account

how men's gender socialisation affects their view of a CSI experience. 'In particular, it is important to address patients' preconceived notions about what constitutes sexual abuse, as the prevailing cultural norm is that precocious sexual activity for boys is "initiation" rather than abuse' (Gartner, 1997b, p.374).

Llewelyn (1997) points out that there is as yet no agreement on the most appropriate model for understanding the consequences of CSA, and that whichever model is used has obvious implications for therapeutic interventions. However, she stresses that there is an emerging consensus on the need for interventions to be responsive to the individual and their unique response pattern, rather than being dependent on any one theory. The results of this study are certainly consistent with this view.

The wide range of proposed sequelae described in this study means that a wide range of clinical interventions may be relevant. For instance, treatments for trauma symptoms based on the PTSD model have been advocated (Briere & Runtz, 1987b; Lindberg & Distad, 1985), as have schema-focused cognitive therapy approaches for changing unhelpful schemas (Padesky, 1994; Jehu, 1992). Many treatment approaches have been based on psychodynamic theories, especially group approaches, and these can be seen to be addressing many of the symptoms related to the traumagenic dynamics model, such as shame, guilt, anger and low self-worth. Bruckner & Johnson (1987) explain the importance of group therapy approaches for male survivors. They say that gender scripts which define the ideal man as strong and in control of his emotions increase the alienation of male survivors, especially from other men. The group process can reduce isolation and normalise the group members' reactions. Of course, treatment approaches for the population in this study must also include those

relevant to offending, such as working with victim empathy (Hildebran & Pithers, 1989) and relapse prevention (Laws, 1989).

Men's socialisation has important implications for therapeutic work as well as for assessment with male survivors, and indeed, for their acceptance of help to begin with. Lisak (1995) has provided a clear analysis of this situation. He stresses that masculine socialisation contributes to many men's hesitancy to seek psychological help. He also suggests that the male survivor's gender 'internalisations' may induce him to 'deny' many of the symptoms related to abuse because he perceives them as emblems of vulnerability and helplessness. He qualifies this statement by adding that: 'this is not to say that the survivor is deliberately deceiving the therapist, although this is also possible, but rather that his denial keeps conscious awareness of his symptoms away from himself, making him unable to report them' (Lisak, 1995, p.264). The findings of the current study appear to be consistent with this opinion. Responding to direct questions about distress and constructions may facilitate this process of 'denial' more than answering a series of questions on standardised measures which are not explicitly linked to the CSI experience. Qualitative data from this study illustrates that this 'denial' may take the form of avoidance:

'The shutters come down. I need a way to keep them up, to find a way to talk about it...I feel in a time warp from when I was happiest, before the abuse started. I need to take a step forward from this. But its like walking towards fire - you automatically step back when it starts to hurt.'

(CSI at age 6 to 16, the perpetrators were his two older sisters).

Lisak (1995) contends that therapists who begin treatment with male survivors must immediately wrestle with the survivor's gender conflict about being a 'victim' and indeed, a recipient of treatment. The true shame experienced by men who are also 'victims' is clearly illustrated by the words of one of the participants:

> *'Shame stopped me telling anyone. I was ashamed that I allowed him to do it in the first place and that I didn't succeed in fighting him or anything'.*
>
> (CSI at age 8, the perpetrator was a male friend aged 9).

This also extends to the emotions experienced in therapy, where the process may involve the experience of painful affect, which in itself may confront the survivor with gender internalisations which tell him that to feel these emotions is to be non-masculine. The implications for clinical work include the need for therapists' awareness of the possible tendency of male survivors to 'deny' symptoms. Further, Lisak (1995) advocates the approach of feminist psychotherapists who include gender analysis in their work, and recognise the sociocultural component, particularly gender socialisation, to each individual's problems. Pasick, Gordon & Meth (1990) argue that men must be helped to recognise the pressures imposed on them by models of masculinity and they advocate actively addressing this by exploring male clients' experiences of gender socialisation. More specifically related to male survivors, Bolton and colleagues (1989) stress that men's gender beliefs about emotional expression must become a focus of treatment.

In effect, the reframing of masculinity has a close relationship with the narrative work with survivors described by Durrant & Kowalski (1990) and White (1995), which

aims to develop a self-perception of competence in place of victimisation. Its treatment goal is to help the client to have control over the influence of the effects of abuse, rather than 'deny' them or be oppressed by them. The value of this approach is certainly implicated by the findings of the current study, particularly because it avoids making assumptions about individual's experiences and meanings of CSI.

4.5 Future Research

Future research should begin by addressing the methodological limitations of the present study. This may include increasing the sample size, developing more comprehensive methods for assessing self-report of distress and nature of constructions, and increasing the scope of symptomatology assessed. Additional outcome measures could include diagnostic and offending factors, and information from the history of participants, such as suicidal behaviour and substance misuse. The identification of suitable control groups would certainly increase the validity of this kind of research, and the use of direct comparison groups, such as non-offenders, would enrich the findings.

Future research could begin to ask why certain men report no distress and positive constructions of their CSI. The current study can only suggest that this occurs. Identifying possible ways that these men differ from others may be a first step. This study suggests that they do not differ greatly on demographics or symptomatology assessed by questionnaire-based measures. However, this study has not investigated whether they differ on the actual nature of their CSI experiences, and this information would be useful. Further, if the nature of CSI could be held constant between these

two groups, then the impact of individual's constructions and self-report would be much more clearly understood.

However, any research that focuses on the nature of CSI would benefit from the corroboration of this information because of the numerous sources of unreliability previously discussed. This study used the corroborating information available in the participants' files, which often consists of the opinions and disclosures of family members, as gathered by the Special Hospital's social workers. However, this kind of information can also be unreliable, and so additional sources of corroboration would be beneficial.

It is difficult to determine the extent of influence of the various group and individual psychological therapies in which participants were engaged on the responses sampled. It may be useful to sample constructions and self-reports of distress at different stages in the treatment process.

The associations identified in the current study between the nature of CSI and questionnaire-based outcome measures are often not strong and very specific. This makes it difficult to draw conclusions about the precise pattern of relationships between the characteristics of CSI and the range of proposed long-term effects. Mendel (1995) believes that conclusions from this kind of research are often too general to be of much use. He calls for greater precision in identifying relationships between factors, especially as greater precision allows for greater attunement in treatment interventions. In order to be more precise, research is required which can draw more confident conclusions about the very specific relationships identified.

The data and analysis available in the current study have only been able to suggest associations, and not the direction of these relationships. Of course, the ideal approach would be a longitudinal, prospective one, which would help to identify causal relationships. This approach would also be able to address the role of other life events and possible mediating variables, as suggested by Cahill and colleagues (1991). Indeed, the role of other factors, such as the severity of the 'abuse', the extent of disclosure, the results of any disclosure, and the use of physical force or threat, could be usefully investigated. Roesler (1994) has described the importance of reactions received to disclosure in a predominantly female sample of survivors.

Finally, it has been highlighted in this study that analysis that depends on group data can lose the complexity and richness of individual experiences. This seems particularly pertinent to this kind of research, where the relationships between variables can be very specific and probably often idiosyncratic, and where the importance of personal definitions and constructions of experiences is seen as pivotal. Individual case analysis would certainly augment group data, but only qualitative approaches could truly identify the complexity of the experience of CSI. Explorative research has a role to play and qualitative techniques can be used to 'ground' the theory which will be used to underpin future quantitative research (Charmaz, 1995).

4.6 Conclusions

i. In a sample of 40 males in a Special Hospital, extensive histories of CSI were disclosed, with most participants experiencing multiple episodes. The pattern of

CSI experience was consistent with that found in research with other male survivor populations. There was a relatively young age at onset, and variation in the frequency and duration of episodes. A significant proportion of episodes comprised isolated incidents, but a similar amount was of extended duration. The majority of episodes involved extra-familial perpetration, but the proportion involving family members was still substantial.

ii. High levels of symptomatology assessed by questionnaire measures were found in the sample, consistent with the findings from research with non-offending survivor populations.

iii. Symptomatology assessed by questionnaire measures was shown in this study to be associated with the characteristics of CSI. However, these associations tended not to be strong, and suggest only very specific relationships. No single characteristic was found to be consistently associated with the outcome measures.

This research suggests associations, but cannot determine any causal relationships between factors.

iv. The sample also displayed high rates of other sequelae that have been associated with the experience of CSI, including psychiatric diagnoses, sexual offending, especially against children, substance and alcohol misuse, and suicidal behaviour. The frequency of the legal category of psychopathic disorder (which implies personality disorder) and histories of sexual offending appeared to be particularly elevated, compared with the total Special Hospital population.

v. However, a large proportion of men in this sample reported no distress as related to CSI and held positive constructions of these experiences. There was a very close relationship between the reporting of distress and the nature of the constructions held.

vi. Nevertheless, the levels of symptomatology assessed by questionnaire measures did not differ greatly between those participants who had reported distress and negative constructions and those who reported no distress and only positive or neutral constructions. The exception was a closer relationship between the self-reporting of current distress and the frequency of trauma symptoms.

vii. The findings have clinical implications. They suggest the need for increased awareness of gender socialisation, and its impact on men's reporting of distress and ways of interpreting their experiences. The need to work directly with this issue in treatment is implicated, and the importance of avoiding reliance on clinician's definitions of and assumptions about 'abuse' is highlighted.

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APPENDICES

1 - Ethical approval

2 - Letter to clinical teams

3 - Letter to participants

4 - Consent form

5 - Life Events Questionnaire

6 - Standardised measures:-

Trauma Symptom Checklist

World Assumptions Scale

Brief Sexual Functioning Questionnaire For Men

Culture-Free Self-Esteem Inventory

Appendix 1

BROADMOOR
HOSPITAL AUTHORITY

Neil Rees
Psychology Department
Broadmoor Hospital

9 October 1997

Dear Mr Rees,

I write to advise you that at their meeting on 7 October 1997, the Ethics Committee approved your research project entitled:

"The impact of childhood sexual interaction on the later psychological functioning of a male forensic population".

If you have any difficulties, please liaise with your hospital-based sponsor and your ethical supervisor, Rev Trevor Walt. You should inform us if there are any changes to the protocol.

The committee wish you well and look forward to hearing from you in due course.

Yours sincerely

Jackie Hayward
Ethics Committee Secretary

cc Dr E Moore
Rev T Walt

shire RG45 7EG Tel 01344 773111 Fax 01344 754625

Dr
RMO, Ward and Wards 5th December 1997

Dear Dr

Re: Research study entitled, 'The impact of childhood sexual interaction on the later psychological functioning of a male forensic population'

I am a final year Clinical Psychologist in Training on the Oxford Regional Training Course, and am currently undertaking a six month placement here at Broadmoor. As part of my doctoral qualification I am hoping to complete a research dissertation which will look at the relationship between male patients' experiences of childhood sexual activity and current psychological functioning.

Description of Study:
Participants will be men who are not actively psychotic and have experienced sexual interaction as a child or adolescent (i.e. aged 16 or under). The procedure will consist of a short semi-structured interview followed by the completion of a small number of standardised measures. The semi-structured interview will be based around a questionnaire which lists a series of life events. Participants will have full control over their disclosure of the events they have experienced, including childhood sexual interaction. At no point will their sexual experience be indicated as the focus of the interview, and details of this will not be sought. It is anticipated that the assessment session will last no longer than an hour. Participants will have the opportunity to meet with me again for debriefing. Full Broadmoor ethics committee approval has been granted for this research.

The following patients of yours have been identified by clinical psychologists working within the department as possible participants for this study:

I would be grateful if you could let me know whether these patients might be approached for their possible participation in this study. With your consent, patients will be contacted individually and given an information sheet regarding the study and an invitation to participate.

The research is supervised by Dr Estelle Moore, Principal Clinical Psychologist. An account of the work will be provided for the Broadmoor Hospital Library in due course. Please do not hesitate to contact me if you require further information.

Yours sincerely,

Neil Rees
Clinical Psychologist in Training
Psychology Department, Broadmoor Hospital

Information for Participants

It is a common idea that what has happened to us in our past influences how we feel about ourselves and how we live our lives now. For some people, certain events from the past 'stay with' them, for others they are forgotten or not thought about. I would like to ask you to join in a project to help understand how events from the past are experienced differently by different people.

I would like to meet with you at least once. In this meeting, which should last around 30-60 minutes, I will ask you what events have occured in your life, how you felt about them at the time and how you feel about them now. I will also ask you to fill in some questionnaires about how you have been feeling recently. I will also offer you the chance to meet up again if you would like to talk more about the information you will have given me.

The interview will be anonymous and confidential, which means that your name will not be used. What you say will only be discussed with the project supervisors, but you will not be identified to them.

Your RMO has given me permission to ask you to take part. If you are willing to join in this research, please sign the research consent form attached. You can withdraw at any time.

Thank you for your time and help.

Neil Rees
Psychology Department

RESEARCH CONSENT FORM

Title of project

.....

.....

Surname .....

Forename .....

Hospital Number .....

Date of Birth .....

House & Ward .....

(a) I ..... HEREBY CONSENT to take part in a clinical research investigation, the nature and purpose of which has been explained to me by ..... and that I have received a written outline of the proposed project.

Date ..... Patient's Signature .....

(b) I ..... CONFIRM that I have explained to ..... the nature and purpose of the proposed clinical research investigation and have handed him/her a written outline of the proposed project.

Date ..... Researcher's Signature .....

(c) I ..... CONFIRM that ..... has explained the nature and purpose of the clinical research investigation to ..... and that he/she has received a written outline of the proposed project.

Date ..... Witness's Signature .....

Top Copy: To Medical Records
Second Copy: To Case Notes: attach to Consent Form Mount Sheet
Third Copy: For Researcher

M. 102

Life Events Questionnaire

It is a common idea that what has happened to us in our past influences how we feel now. This questionnaire sets out to discover what events have occured in your life, how you felt about them at the time and how you feel about them now.

Look at the list of life events below and circle the **yes** next to those that have happened to you in the past and circle the **no** next to those that have not. If you circle **yes** for an event, go on to answer the further four questions about that event. If you circle **no**, move on to the next life event.

EXAMPLE:

Life event	Circle yes or no		
Death of a family pet	(Yes) No	If yes, continue →	1. Indicate to what extent this experience was good or bad by circling the phrase that best describes how you felt at the time:- Very Good / Good / Neither good nor bad / (Bad) / Very Bad 2. And how you feel about it now:- Very Good / Good / (Neither good nor bad) / Bad / Very Bad 3. Indicate to what extent this experience distressed you (if at all) by circling the phrase that best describes how you felt at the time:- Not at all Distressed / Mildly Distressed / (Moderately Distressed) / Very Distressed 4. And how it makes you feel now:- (Not at all Distressed) / Mildly Distressed / Moderately Distressed / Very Distressed

Responding to some of the following questions may cause you distress. If it becomes too distressing for you either:-

- put aside the questionnaire for a while or
- talk to me about how you feel.

Now start with the first life event on the next page. Thank you.

Life event	Circle yes or no		
1. Death of partner	Yes / No	If yes, continue →	1. Indicate to what extent this experience was good or bad by circling the phrase that best describes how you felt at the time:- Very Good / Good / Neither good nor bad / Bad / Very Bad 2. And how you feel about it now:- Very Good / Good / Neither good nor bad / Bad / Very Bad 3. Indicate to what extent this experience distressed you (if at all) by circling the phrase that best describes how you felt at the time:- Not at all Distressed / Mildly Distressed / Moderately Distressed / Very Distressed 4. And how it makes you feel now:- Not at all Distressed / Mildly Distressed / Moderately Distressed / Very Distressed
2. Divorce/end of relationship with partner	Yes / No	If yes, continue →	1. Indicate to what extent this experience was good or bad by circling the phrase that best describes how you felt at the time:- Very Good / Good / Neither good nor bad / Bad / Very Bad 2. And how you feel about it now:- Very Good / Good / Neither good nor bad / Bad / Very Bad 3. Indicate to what extent this experience distressed you (if at all) by circling the phrase that best describes how you felt at the time:- Not at all Distressed / Mildly Distressed / Moderately Distressed / Very Distressed 4. And how it makes you feel now:- Not at all Distressed / Mildly Distressed / Moderately Distressed / Very Distressed

Life event	Circle yes or no		
3. Death of parent	Yes / No	If yes, continue →	1. Indicate to what extent this experience was good or bad by circling the phrase that best describes how you felt at the time:- Very Good / Good / Neither good nor bad / Bad / Very Bad 2. And how you feel about it now:- Very Good / Good / Neither good nor bad / Bad / Very Bad 3. Indicate to what extent this experience distressed you (if at all) by circling the phrase that best describes how you felt at the time:- Not at all Distressed / Mildly Distressed / Moderately Distressed / Very Distressed 4. And how it makes you feel now:- Not at all Distressed / Mildly Distressed / Moderately Distressed / Very Distressed
4. Death of brother or sister	Yes / No	If yes, continue →	1. Indicate to what extent this experience was good or bad by circling the phrase that best describes how you felt at the time:- Very Good / Good / Neither good nor bad / Bad / Very Bad 2. And how you feel about it now:- Very Good / Good / Neither good nor bad / Bad / Very Bad 3. Indicate to what extent this experience distressed you (if at all) by circling the phrase that best describes how you felt at the time:- Not at all Distressed / Mildly Distressed / Moderately Distressed / Very Distressed 4. And how it makes you feel now:- Not at all Distressed / Mildly Distressed / Moderately Distressed / Very Distressed

Life event	Circle yes or no		
5. Divorce/separation of parents	Yes / No	If yes, continue →	1. Indicate to what extent this experience was good or bad by circling the phrase that best describes how you felt at the time:- Very Good / Good / Neither good nor bad / Bad / Very Bad 2. And how you feel about it now:- Very Good / Good / Neither good nor bad / Bad / Very Bad 3. Indicate to what extent this experience distressed you (if at all) by circling the phrase that best describes how you felt at the time:- Not at all Distressed / Mildly Distressed / Moderately Distressed / Very Distressed 4. And how it makes you feel now:- Not at all Distressed / Mildly Distressed / Moderately Distressed / Very Distressed
6. Being bullied in school	Yes / No	If yes, continue →	1. Indicate to what extent this experience was good or bad by circling the phrase that best describes how you felt at the time:- Very Good / Good / Neither good nor bad / Bad / Very Bad 2. And how you feel about it now:- Very Good / Good / Neither good nor bad / Bad / Very Bad 3. Indicate to what extent this experience distressed you (if at all) by circling the phrase that best describes how you felt at the time:- Not at all Distressed / Mildly Distressed / Moderately Distressed / Very Distressed 4. And how it makes you feel now:- Not at all Distressed / Mildly Distressed / Moderately Distressed / Very Distressed

Life event	Circle yes or no		
7. Physical violence as a child from parent	Yes / No	If yes, continue →	1. Indicate to what extent this experience was good or bad by circling the phrase that best describes how you felt at the time:- Very Good / Good / Neither good nor bad / Bad / Very Bad 2. And how you feel about it now:- Very Good / Good / Neither good nor bad / Bad / Very Bad 3. Indicate to what extent this experience distressed you (if at all) by circling the phrase that best describes how you felt at the time:- Not at all Distressed / Mildly Distressed / Moderately Distressed / Very Distressed 4. And how it makes you feel now:- Not at all Distressed / Mildly Distressed / Moderately Distressed / Very Distressed
8. Physical violence as a child from other adult (please specifiy the adult involved .....)	Yes / No	If yes, continue →	1. Indicate to what extent this experience was good or bad by circling the phrase that best describes how you felt at the time:- Very Good / Good / Neither good nor bad / Bad / Very Bad 2. And how you feel about it now:- Very Good / Good / Neither good nor bad / Bad / Very Bad 3. Indicate to what extent this experience distressed you (if at all) by circling the phrase that best describes how you felt at the time:- Not at all Distressed / Mildly Distressed / Moderately Distressed / Very Distressed 4. And how it makes you feel now:- Not at all Distressed / Mildly Distressed / Moderately Distressed / Very Distressed

For the following life events, 'sexual interaction' covers a broad range of activities, anything from playing 'doctor' or looking at sexual pictures together, to sexual intercourse - in fact, anything that seemed 'sexual' to you.

All of the events refer to sexual interaction you had when you were a child or adolescent...

Life event	Circle yes or no		
9. ...with another child or adolescent who was female	Yes / No	If yes, continue →	1. Indicate to what extent this experience was good or bad by circling the phrase that best describes how you felt at the time:- Very Good / Good / Neither good nor bad / Bad / Very Bad 2. And how you feel about it now:- Very Good / Good / Neither good nor bad / Bad / Very Bad 3. Indicate to what extent this experience distressed you (if at all) by circling the phrase that best describes how you felt at the time:- Not at all Distressed / Mildly Distressed / Moderately Distressed / Very Distressed 4. And how it makes you feel now:- Not at all Distressed / Mildly Distressed / Moderately Distressed / Very Distressed

Life event	Circle yes or no		
10. ...with another child or adolescent who was male	Yes / No	If yes, continue →	1. Indicate to what extent this experience was good or bad by circling the phrase that best describes how you felt at the time:- Very Good / Good / Neither good nor bad / Bad / Very Bad 2. And how you feel about it now:- Very Good / Good / Neither good nor bad / Bad / Very Bad 3. Indicate to what extent this experience distressed you (if at all) by circling the phrase that best describes how you felt at the time:- Not at all Distressed / Mildly Distressed / Moderately Distressed / Very Distressed 4. And how it makes you feel now:- Not at all Distressed / Mildly Distressed / Moderately Distressed / Very Distressed
11. ...with an adult female who was not a member of your family (please specify number of different adult females.....)	Yes / No	If yes, continue →	1. Indicate to what extent this experience was good or bad by circling the phrase that best describes how you felt at the time:- Very Good / Good / Neither good nor bad / Bad / Very Bad 2. And how you feel about it now:- Very Good / Good / Neither good nor bad / Bad / Very Bad 3. Indicate to what extent this experience distressed you (if at all) by circling the phrase that best describes how you felt at the time:- Not at all Distressed / Mildly Distressed / Moderately Distressed / Very Distressed 4. And how it makes you feel now:- Not at all Distressed / Mildly Distressed / Moderately Distressed / Very Distressed

Life event	Circle yes or no		
12. ...with an adult male who was not a member of your family (please specify number of different adult males.....)	Yes / No	If yes, continue →	1. Indicate to what extent this experience was good or bad by circling the phrase that best describes how you felt at the time:- Very Good / Good / Neither good nor bad / Bad / Very Bad 2. And how you feel about it now:- Very Good / Good / Neither good nor bad / Bad / Very Bad 3. Indicate to what extent this experience distressed you (if at all) by circling the phrase that best describes how you felt at the time:- Not at all Distressed / Mildly Distressed / Moderately Distressed / Very Distressed 4. And how it makes you feel now:- Not at all Distressed / Mildly Distressed / Moderately Distressed / Very Distressed
13. ...with a member of your family other than your mother or father (please specify person and their age .....)	Yes / No	If yes, continue →	1. Indicate to what extent this experience was good or bad by circling the phrase that best describes how you felt at the time:- Very Good / Good / Neither good nor bad / Bad / Very Bad 2. And how you feel about it now:- Very Good / Good / Neither good nor bad / Bad / Very Bad 3. Indicate to what extent this experience distressed you (if at all) by circling the phrase that best describes how you felt at the time:- Not at all Distressed / Mildly Distressed / Moderately Distressed / Very Distressed 4. And how it makes you feel now:- Not at all Distressed / Mildly Distressed / Moderately Distressed / Very Distressed

Life event	Circle yes or no		
14. ...with your mother	Yes / No	If yes, continue →	1. Indicate to what extent this experience was good or bad by circling the phrase that best describes how you felt at the time:- Very Good / Good / Neither good nor bad / Bad / Very Bad 2. And how you feel about it now:- Very Good / Good / Neither good nor bad / Bad / Very Bad 3. Indicate to what extent this experience distressed you (if at all) by circling the phrase that best describes how you felt at the time:- Not at all Distressed / Mildly Distressed / Moderately Distressed / Very Distressed 4. And how it makes you feel now:- Not at all Distressed / Mildly Distressed / Moderately Distressed / Very Distressed
15. ...with your father	Yes / No	If yes, continue →	1. Indicate to what extent this experience was good or bad by circling the phrase that best describes how you felt at the time:- Very Good / Good / Neither good nor bad / Bad / Very Bad 2. And how you feel about it now:- Very Good / Good / Neither good nor bad / Bad / Very Bad 3. Indicate to what extent this experience distressed you (if at all) by circling the phrase that best describes how you felt at the time:- Not at all Distressed / Mildly Distressed / Moderately Distressed / Very Distressed 4. And how it makes you feel now:- Not at all Distressed / Mildly Distressed / Moderately Distressed / Very Distressed

The Trauma Symptom Checklist - 40

Appendix 6

How often have you experienced each of the following in the **last two months**? Circle the number of your response.

	Never	Infrequently	Sometimes	Very Often	Always
Headaches	0	1	2	3	4
Insomnia (trouble getting to sleep)	0	1	2	3	4
Weight loss (without dieting)	0	1	2	3	4
Stomach problems	0	1	2	3	4
Sexual problems	0	1	2	3	4
Feeling isolated from others	0	1	2	3	4
'Flashbacks' (sudden, vivid, distracting memories)	0	1	2	3	4
Restless sleep	0	1	2	3	4
Low sex drive	0	1	2	3	4
Anxiety attacks	0	1	2	3	4
Sexual overactivity	0	1	2	3	4
Loneliness	0	1	2	3	4
Nightmares	0	1	2	3	4
'Spacing out' (going away in your mind)	0	1	2	3	4
Sadness	0	1	2	3	4
Dizziness	0	1	2	3	4
Not feeling satisfied with your sex life	0	1	2	3	4
Trouble controlling your temper	0	1	2	3	4
Waking up early in the morning and can't get back to sleep	0	1	2	3	4
Uncontrollable crying	0	1	2	3	4

	Never	Infrequently	Sometimes	Very Often	Always
Fear of men	0	1	2	3	4
Not feeling rested in the morning	0	1	2	3	4
Having sex that you didn't enjoy	0	1	2	3	4
Trouble getting along with others	0	1	2	3	4
Memory problems	0	1	2	3	4
Desire to physically hurt yourself	0	1	2	3	4
Fear of women	0	1	2	3	4
Waking up in the middle of the night	0	1	2	3	4
Bad thoughts or feelings during sex	0	1	2	3	4
Passing out	0	1	2	3	4
Feeling that things are 'unreal'	0	1	2	3	4
Unnecessary or over-frequent washing	0	1	2	3	4
Feelings of inferiority	0	1	2	3	4
Feeling tense all the time	0	1	2	3	4
Being confused about your sexual feelings	0	1	2	3	4
Desire to physically hurt others	0	1	2	3	4
Feelings of guilt	0	1	2	3	4
Feelings that you are not always in your body	0	1	2	3	4
Having trouble breathing	0	1	2	3	4
Sexual feelings when you shouldn't have them	0	1	2	3	4

The World Assumptions Scale

DIRECTIONS: Beside each statement is a scale which ranges from strongly disagree (1) to strongly agree (6). For each item, circle the number which best represents the extent to which you disagree or agree with the statement. The more strongly you agree with a statement the higher will be the number you circle. Please make sure that you answer every time and that you circle only one number per item. Since this is a measure of beliefs, there are no right or wrong answers.

It is important that you respond according to your actual beliefs and not according to how you feel you should believe, or how you think others want you to believe.

	Strongly Disagree	Moderately Disagree	Slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree
Misfortune is least likely to strike worthy, decent people	1	2	3	4	5	6
People are naturally unfriendly and unkind	1	2	3	4	5	6
Bad events are distributed to people at random	1	2	3	4	5	6
Human nature is basically good	1	2	3	4	5	6
The good things that happen in this world far outnumber the bad	1	2	3	4	5	6
The course of our lives is largely determined by chance	1	2	3	4	5	6
Generally, people deserve what they get in this world	1	2	3	4	5	6
I often think I am no good at all	1	2	3	4	5	6
There is more good than evil in this world	1	2	3	4	5	6

	Strongly Disagree	Moderately Disagree	Slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree
I am basically a lucky person	1	2	3	4	5	6
People's misfortunes result from mistakes they have made	1	2	3	4	5	6
People don't really care what happens to the next person	1	2	3	4	5	6
I usually behave in ways that are likely to maximise good results for me	1	2	3	4	5	6
People will experience good fortune if they themselves are good	1	2	3	4	5	6
Life is full of uncertainties that are determined by chance	1	2	3	4	5	6
When I think about it, I consider myself very lucky	1	2	3	4	5	6
I almost always make an effort to prevent bad things from happening to me	1	2	3	4	5	6
I have a low opinion of myself	1	2	3	4	5	6
By and large, good people get what they deserve in this world	1	2	3	4	5	6
Through our actions, we can prevent bad things from happening to us	1	2	3	4	5	6

	Strongly Disagree	Moderately Disagree	Slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree
Looking at my life, I realise that chance events have worked out well for me	1	2	3	4	5	6
If people took preventative actions, most misfortune could be avoided	1	2	3	4	5	6
I take the actions necessary to protect myself against misfortune	1	2	3	4	5	6
In general, life is mostly a gamble	1	2	3	4	5	6
The world is a good place	1	2	3	4	5	6
People are basically kind and helpful	1	2	3	4	5	6
I usually behave as to bring about the greatest good for me	1	2	3	4	5	6
I am very satisfied with the kind of person I am	1	2	3	4	5	6
When bad things happen, it is typically because people have not taken the necessary actions to protect themselves	1	2	3	4	5	6
If you look closely enough, you will see that the world is full of goodness	1	2	3	4	5	6
I have a reason to be ashamed of my personal character	1	2	3	4	5	6
I am luckier than most people	1	2	3	4	5	6

The Brief Sexual Function Questionnaire for Men (Adapted)

DIRECTIONS: Answer the following questions by choosing the most accurate responses for the past month. Circle the number of your response.

1. During the past month, how frequently have you felt **sexual drive***?

Not at all	Once during the month	2 or 3 times during the month	Once a week	2 or 3 times per week	Once a day	More than once a day
0	1	2	3	4	5	6

2. During the past month, how frequently have you had sexual thoughts, fantasies, or erotic dreams?

Not at all	Once during the month	2 or 3 times during the month	Once a week	2 or 3 times per week	Once a day	More than once a day
0	1	2	3	4	5	6

* This feeling may include wanting to have sexual experience (masturbation or intercourse), planning to have sex, feeling frustrated due to lack of sex, etc.

3. How frequently have you engaged in the following sexual experiences during the past month?

	Not at all	Once during the month	2 or 3 times during the month	Once a week	2 or 3 times per week	Once a day	More than once a day
a. Solitary masturbation	0	1	2	3	4	5	6
b. Petting or foreplay	0	1	2	3	4	5	6
c. Oral sex	0	1	2	3	4	5	6
d. Vaginal intercourse	0	1	2	3	4	5	6
e. Anal intercourse	0	1	2	3	4	5	6

4. During the past month, has the frequency of your sexual activity with another person been:

1. Less than you desire
2. As much as you desire
3. More than you desire

5. If another person makes sexual advances, how have you usually responded during the past month?

0. Has not happened in the past month
1. Usually refuse
2. Sometimes refuse
3. Accept reluctantly
4. Accept, but not necessarily with pleasure
5. Usually accept with pleasure
6. Always accept with pleasure

6. Overall, during the past month, how satisfied have you been with your sex life?

1. Completely satisfied
2. Moderately satisfied
3. Slightly satisfied
4. Neither satisfied, nor dissatisfied
5. Slightly dissatisfied
6. Moderately dissatisfied
7. Completely dissatisfied

7. And, thinking of a time when you were more free to have a sex life, how satisfied generally were you with your sex life?

1. Completely satisfied
2. Moderately satisfied
3. Slightly satisfied
4. Neither satisfied, nor dissatisfied
5. Slightly dissatisfied
6. Moderately dissatisfied
7. Completely dissatisfied

8. Circle the number that corresponds to the statement that best describes your sexual experience.

1. I have only had sex with women
2. I have mainly had sex with women and have some experience of sex with men
3. I have mainly had sex with women and have considerable experience of sex with men
4. I have had sex equally with women and men
5. I have mainly had sex with men and have considerable experience of sex with women
6. I have mainly had sex with men and have some experience of sex with women
7. I have only had sex with men
8. I have no sexual experience

9. Circle the number that corresponds to the statement that best describes your sexual desires.

1. To only have sex with women
2. To mainly have sex with women and some desire to have sex with men
3. To mainly have sex with women and considerable desire to have sex with men
4. To have sex equally with women and men
5. To mainly have sex with men and considerable desire to have sex with women
6. To mainly have sex with men and some desire to have sex with women
7. To only have sex with men
8. I have no sexual desire

10. How many female sexual partners have you had in your life?

1. None
2. One
3. Two
4. 3-5
5. 6-10
6. 11-15
7. 16-20
8. More than 20

11. How many male sexual partners have you had in your life?

1. None
2. One
3. Two
4. 3-5
5. 6-10
6. 11-15
7. 16-20
8. More than 20

12. Do you consider yourself to have a sexual problem?

1. Yes 2. No

If yes, please write below what the problem is for you

.....

.....

.....

.....

13. On the following scale, please rate your overall sexual adjustment:

1	2	3	4	5
Poorly adjusted		Average		Well adjusted

CULTURE - FREE SEI

NAME.....AGE.....DATE OF BIRTH.....

DATE.....TOTAL.....G.....S.....P.....I.....

DIRECTIONS

PLEASE MARK EACH QUESTION IN THE FOLLOWING WAY:

IF THE QUESTION DESCRIBES HOW YOU USUALLY FEEL, MAKE A CHECK MARK (✓) IN THE "YES" COLUMN.

IF THE QUESTION DOES NOT DESCRIBE HOW YOU USUALLY FEEL, MAKE A CHECK MARK (✓) IN THE "NO" COLUMN.

PLEASE CHECK ONLY ONE COLUMN (EITHER "YES" OR "NO") FOR EACH OF THE FORTY QUESTIONS. THIS IS NOT A TEST, THERE ARE NO RIGHT OR WRONG ANSWERS.

	YES	NO
1. Do you have only a few friends?		
2. Are you happy most of the time?		
3. Can you do most things as well as others?		
4. Do you like everyone you know?		
5. Do you spend most of your free time alone?		
6. Do you like being a male?/~~Do you like being a female~~?		
7. Do most people you know like you?		
8. Are you usually successful when you attempt important tasks?		
9. Have you ever taken anything that did not belong to you?		
10. Are you as intelligent as most people?		
11. Do you feel you are as important as most people?		
12. Are you easily depressed?		
13. Would you change many things about yourself if you could?		
14. Do you always tell the truth?		
15. Are you as nice looking as most people?		
16. Do many people dislike you?		
17. Are you usually tense or anxious?		
18. Are you lacking in self confidence?		
19. Do you gossip at times?		
20. Do you often feel that you are no good at all?		
21. Are you as strong and healthy as most people?		
22. Are your feelings easily hurt?		
23. Is it difficult to express your views and feelings?		
24. Do you ever get angry?		
25. Do you often feel ashamed of yourself?		
26. Are other people generally more successful than you are?		
27. Do you feel uneasy much of the time without knowing why?		
28. Would you like to be as happy as other people appear to be?		
29. Are you ever shy?		
30. Are you a failure?		
31. Do people like your ideas?		
32. Is it hard for you to meet new people?		
33. Do you ever lie?		
34. Are you often upset about something?		
35. Do most people respect your views?		
36. Are you more sensitive than most people?		
37. Are you as happy as most people?		
38. Are you ever sad?		
39. Are you definitely lacking in initiative?		
40. Do you worry alot?		